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	17E534	A. BUILDING _____ B. WING _____	05/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATTICA LONG TERM CARE FACILITY	302 N BOTKIN ATTICA, KS 67009

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey. A revised 2567 was sent electronically to the facility on 5/28/13.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 157	Continued From page 1 legal representative or interested family member. This REQUIREMENT is not met as evidenced by: The facility census totaled 50 residents with 21 included in the sample. Based on observation, interview and record review, the facility failed to notify the physician of 1 sampled resident's continued weight loss (#29) and another sampled resident's high blood sugars (#5). Findings included: - Review of resident #5's physician's orders, signed on 5/6/13, identified the resident with the diagnosis of diabetes mellitus. The review of orders directed staff to monitor the resident's blood sugars four times a day on Mondays, Wednesdays, and Fridays. According to the physician's progress notes on 4/5/13 at 4:04 p.m., the physician had to change the resident oral diabetic medicine from Glyburide to Glipizide 10 mg (milligrams) BID (twice a day) because of restricts from the resident's prescription carrier. The physician noted that the resident's blood sugar had to be followed for a little while until the physician was secure the resident's blood sugars were not affected by the switch in medications. Review of the facility's March 2013's blood sugar monitoring sheets revealed the following blood sugars: --On 3/6/13 at the 2:00 pm check, blood sugar was 324 mg/dL (normal is 60-140 mg/dL):	F 157		

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Review of the nurse's notes revealed it lacked notification of the physician.

--On 3/11/13 at 2:00 pm check, blood sugar was 407 mg/dL: Review of the nurse's notes revealed it lacked notification of the physician.

--On 3/13/13 at 10:00 am check, blood sugar was 383 mg/dL: Review of the nurse's notes revealed lacked notification of the physician.

Review of the facility's April 2013 blood sugar monitoring sheets revealed the following blood sugars:

--On 4/17/13 at 8:00 pm check, blood sugar was 351 mg/dL. Review of the nurse's notes revealed they lacked notification of the physician.

--On 4/21/13 at 8:00 pm check, blood sugar was 369 mg/dL: Review of the nurse's notes revealed they lacked notification of the physician.

Review of the May blood sugar monitoring sheets revealed the resident did not have any abnormally high or low blood sugars.

On 5/9/13 at 12:51 p.m. Licensed nursing staff J thought that the staff used standing orders given by the physician on blood sugar parameters for when to notify the physician. Looked at the standing orders for resident #5 and revealed that the physician had not left parameters for the staff to follow. Staff J stated sometimes the doctors order specific guidelines, otherwise, we call if it falls below 60 mg/dL or goes over 300 mg/dL.

On 5/9/13 at 1:12 p.m., Licensed nursing staff C

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stated that the standing orders for all residents included blood sugar parameters, but when looked at resident #5's standing orders revealed that the only standing order in regard to diabetics included "Nurse may use judgement and wait to give insulin shot to see if resident is going to eat first PRN (as needed)". Staff C agreed with staff J and stated that the staff should call for any blood sugar that fell below 60 mg/dL or went above 300 mg/dL.

On 5/9/13 at 2:51 p.m. Administrative Nurse K stated that the staff should get parameters for blood sugars off of the physician's standing orders. When told that the staff looked and the physician's standing orders for resident #5 lacked parameters, staff K confirmed the facility did not have a standard parameter to notify the physician with, however, he/she would expect the staff to document and notify the physician if the blood sugar was over 300 mg/dL or less than 60 mg/dL.

The facility failed to notify the physician when a diabetic resident's blood sugars repeatedly went over 300 mg/dL.

- Review of resident #29's annual MDS (minimum data set) dated 10/8/12, revealed a staff assessment for mental status score of 2 (moderately impaired). The resident weighed 112 lbs. The resident required set up and supervision with eating.

Review of the quarterly MDS dated 12/24/12 revealed the resident had a significant weight loss, (5% in 1 month or 10% in last 6 months) and was not on a weight loss program. Residents weight 104 pounds.

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Review of the last quarterly MDS dated 3/18/13 revealed the resident was 57 inches and 102 pounds

Review of the resident care plan with a date of 3/26/13 direct staff to provide supplement with all meals. At the times the resident was unable to sit at the table for meals, offer food that he/she could carry and eat while ambulating in the hall.

On 2/12/13, the Nutritional progress note revealed the resident, paced the halls and was constantly on the move. The staff reported the resident drank shakes (supplemental nutrition) and received snacks. The resident had significant weight loss for 30 and 180 days. Meal intake revealed minor decrease in the intake changes in comparing January 2013 and February 2013. The resident had fair intake overall, but not adequate to support his/her activity level requirements. Further review of the progress notes revealed recommendation that staff offer a shake every meal and between if he/she will drink it, also, offer chocolate donuts and other snacks he/she likes. The progress note lacked documentation that the physician was notified of the resident's significant weight loss.

On 3/25/13 Dietary progress notes revealed that a dietary suggestion to staff was to re-evaluate and to give 2 shakes with each meal, and, offer foods between meals.

On 5/7/13 at 12:32 p.m., observation revealed the staff served, a Pork Medallion, a serving of cheese potatoes, spinach, scalloped apples, and a glass of water and tea. The resident had

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F 157	Continued From page 5 consumed all but 2 bites of the Pork Medallion, 1/2 of the potatoes, 1/2 of the spinach and no apples were eaten. The resident also consumed 2 mighty shakes. On 5/7/13 at 12:56 p.m., observation revealed the resident remained at the table picking at the spinach and seemed to be the only thing he/she ate. The resident ate 60 % of the food and drank 100 % of both shakes. The resident ate strawberry poke cake and punch for the afternoon snack. On 5/8/13 at 9:15 a.m., an interview with licensed nursing staff V revealed the dietician kept track of the weights and let the nurses know of the weight loss/gain trends. The nurses also trended and notified the physician of 2-3 pounds weight loss in a week would be a significant. (Resident has been on a slow steady weight loss decline since January of 2012 weight records). On 5/9/13 at 10:20 a.m., interview with administrative nursing staff K revealed the physician should be notified of significant loss of (5% in 1 month and 10% in the last 6 months). Staff are expected to call the physician every week with significant weight loss until the physician acknowledges the weight loss. The facility failed to notify the resident's physician of a continual and significant weight loss for resident # 29.	F 157		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with	F 248		

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the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.

This REQUIREMENT is not met as evidenced by:
The facility census totaled 50 residents with 21 included in the sample. Based on observation, interview and record review of 3 residents reviewed for activities the facility failed to invite and provide an ongoing program of activities designed to meet the interest and enhance the resident's well-being for 3 of 3 residents with wandering behaviors. (#59, #40, & #26)

Findings Included:

- Review of resident #26's signed physician order sheet dated 4-3-13 included the following diagnoses: anxiety state (a mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), dementia (progressive mental disorder characterized by failing memory, confusion) with behaviors, and depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, melancholy, dejection, worthlessness, emptiness and hopelessness).

Review of the admission MDS (Minimum Data Set 3.0, a required assessment) dated 9-16-12 revealed a BIMS (Brief Interview for Mental Status) score of 3, indicating severe cognitive deficit. The MDS revealed it was very important for the resident to do his/her favorite activities and participate in religious services, and somewhat important to do things with groups of people. It

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revealed the resident required extensive assistance of 1 staff with all ADL's (Activities of Daily Living) except for limited assistance of 1 staff with walking and locomotion.

Review of the Care Area Triggers revealed activities and psychosocial services did not trigger for further assessment.

Review of the Cognitive CAA (Care Area Assessment) revealed the resident had dementia with anxiety and usually understood others. It revealed the resident could also usually make him/herself understood but mumbled and spoke very quietly. The CAA's lacked any mention of the resident's specific likes and dislikes for activities.

Review of the care plan last reviewed on 3-6-13 revealed under the general information staff were to invite the resident to activities and he/she would join as he/she chose. The care plan lacked any further mention of activities the resident liked, such as: bus rides, walking/wheeling outside, music, or other identified interests.

The care plan directive sheet provided to the aides also lacked any specific activities of interest the staff needed to invite the resident to attend.

Review of the recreation assessment dated 9-6-12 revealed the resident's current interest included cards and other games, crafts, exercise, music, spiritual activities, and walk/wheeling outdoors.

Review of the activity notes dated 12-6-12

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revealed the resident enjoyed sing-a-longs, music, kickball, and exercise. The resident also enjoyed reading mail, the local newspaper, and strolls about the facility.

Review of the activity calendar for the month of May revealed that on 5-7-13 at 2:00 p.m. there was a nurse's party and kickball at 4:00 p.m. On 5-8-13 it revealed kickball was at 10:30 a.m., coconut cream pie/coffee at 3:00 p.m. and nails at 4:00 p.m.

An observation on 5-7-13 at 1:48 p.m. the resident lay in bed on his/her right side with covers on. Observations made on 5-7-13 between 1:48 p.m. and 2:34 p.m. revealed that staff did not go into the resident's room to invite him/her to the nurse's party even though staff went into other residents' rooms to invite them to the party. During this time the resident remained on his/her right side with knees drawn up and covers on.

Observation on 5-7-13 at 3:49 p.m. and 4:23 p.m. of the activity room revealed the resident was not in the activity room participating in the nurse's party or kickball activity. Observation of the resident at these times revealed the resident lay in bed.

On 5-8-13 at 3:14 p.m. revealed staff invited other residents to the coconut cream pie/coffee activity but did not invite resident #26.

An observation on 5-8-13 at 4:25 p.m. revealed staff pushed the resident to the activity room and he/she sat in wheelchair facing the exit door to go outside. The resident sat with other residents in a

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partial circle with a certified nurse aide providing nail care for 1 resident, a few residents visited with each other but no other organized activity going on at that time.

Observations made at intermittent times on 5-7-13 and 5-8-13 when the different activities were going on revealed the resident did not participate in any of the afternoon activities listed during these days and did not participate in the kickball on the morning of 5-8-13.

A confidential interview during the survey dated 5-7,8,9 -13, it was reported that when they saw the resident staff did not go into the resident's room and invite or encourage the resident to attend activities.

During an interview on 5-8-13 at 3:23 p.m. direct care staff W reported the activity staff go around and remind the residents what is going on and invite the residents to come. He/she also reported that if activity staff did not go in the nurse aides would go in and invite the residents to go to the activity. Staff W reported the resident was more of a wanderer and sometimes didn't want to go and other times he/she would just roam around and wasn't one for being still in one place for very long.

During an interview on 5-9-13 at 7:49 a.m. direct care staff E reported the resident propelled self around the facility before and after supper. He/she reported the resident really liked kickball and did not get into much else. Staff E reported the resident used to lay him/herself down, was always cold, and got frustrated.

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During an interview on 5-9-13 at 7:37 a.m. direct care staff N and staff Y reported they incorporate things the resident liked to do with the monthly activities. Staff N reported an assessment was completed when the resident first came in and then tried to encourage them to attend the activities. Staff N reported all residents were invited if able to do some of the things done in the facility. Staff N & staff Y reported the resident took a lot of one on one supervision, "loved kickball" and music or sing along.

Review of the activity department policy with a revision date of 8-2011 under the Purpose revealed guidance to staff "To provide entertainment for all residents residing in (the facility)." It also revealed - "A. When time for a scheduled activity, any staff, but usually activity staff will ask resident if they wish to participate in the upcoming activities ... If resident refuses activity a second attempt will be made by another staff member to ensure that the resident does not wish to participate."

The facility failed to invite a resident to activities of interest and implement an ongoing activity program to meet the interest of the resident.

- Review of resident #59's signed physician order sheet dated 4-11-13 included the following diagnoses: Dementia, (progressive mental disorder characterized by failing memory, confusion) with behaviors/agitation.

Review of the admission MDS (Minimum Data Set 3.0, a required assessment) dated 4-22-12 revealed a BIMS (Brief Interview for Mental Status) score of 2 that indicated severe cognitive

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impairment. It also revealed the resident had difficulty focusing, easily distracted and had disorganized thinking that fluctuated throughout the day. It also revealed the resident had physical and verbal behaviors toward others, which put the resident at risk for physical illness or injury, and had other inappropriate behaviors not directed at others 1-3 days out of past 7. It revealed the resident's preferences for routine that most things were not very important to the resident including participating in favorite activities or religious events. It revealed the resident required extensive assistance of 1 for all cares except for walking in room which required limited assistance of 1 staff. It also revealed the resident had moderately impaired vision and could not read newspaper headlines but could identify objects.

Review of the CAT's (Care Area Triggers) for the above MDS revealed activities did not trigger for further assessment.

Review of the Psychosocial Well-being CAA (Care Area Assessment) dated 4-23-13 revealed the resident resisted assistance, reported that he/she would be better off dead but would not hurt him/herself. It also revealed the resident reported he/she did not have anything of interest other than listening to other people talk and interact.

Review of the care plan dated 4-14-13 revealed the resident used to be a farmer and liked to sit and listen to people talk, enjoyed getting a coke, and wanted staff to take him/her to activities and such so that he/she could listen to the other people.

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An observation on 5-7-13 at 11:37 a.m. revealed the resident laid in bed on his/her back with eyes closed, TV turned off and at 12:43 p.m. the resident remained in bed.

An observation on 5-7-13 at 1:32 p.m. the resident's alarm sounded and staff responded promptly and turned off alarm. At 1:49 p.m. licensed nursing staff Z and direct care staff AA assisted the resident to get out of bed and into the wheelchair. Staff put a pillow on the resident's left side to help in maintaining proper upright position in the chair and then pushed the resident to the dining room to eat lunch.

On 5-8-13 at 3:14 p.m. staff were inviting other residents to the coconut cream pie/coffee activity but did not invite resident #59.

During an interview on 5-7-13 at 1:12 p.m. direct care staff AA reported the staff had to watch the resident when in the wheel chair because he/she would lean a lot and might fall out of the wheelchair. Staff AA also reported they had to guide and cue the resident due to not being able to see well and he/she could get agitated when he/she did not know what was going on. When asked if the resident went to activities staff AA reported that sometimes he/she did but usually slept instead.

During an interview on 5-8-13 at 3:23 p.m. direct care staff W reported that all the residents got invited to the activities but not all of them want to go.

During an interview on 5-9-13 at 7:49 a.m. direct

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care staff E reported they thought nursing staff kept the resident in bed because someone told him/her the resident had a stroke so he could not maintain his/her position in the wheelchair. At this same time direct care staff AA reported he/she also thought the resident laid down after every meal was because of positioning in the wheelchair. Staff AA reported the resident would lean forward and fell in activities and nursing staff were asked to lay him down.

During an interview on 5-9-13 at 1:57 p.m. Administrative nurse D reported he/she expected staff to invite all residents to the activities. He/she reported that just because a resident is a fall risk or wanders and did not like to stay in the activities or even if a resident had behaviors, that was not a reason for them to not attend the activities. Staff was still expected to invite them and encourage them to come

Review of the activity department policy with a revision date of 8-2011 under the Purpose revealed guidance to staff "To provide entertainment for all residents residing in (the facility)." It also revealed - "A. When time for a scheduled activity, any staff, but usually activity staff will ask resident if they wish to participate in the upcoming activities ... If resident refuses activity a second attempt will be made by another staff member to ensure that the resident does not wish to participate."

The facility failed to invite and provide an ongoing program of activities that meet the interest of the resident, including sitting and listening to others during the activities.

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- Review of the physician's review of orders for resident #40, signed on 5/1/13, revealed the resident had the following diagnoses: Left-sided hemiplegia (paralysis on the left side), joint contracture (chronic loss of joint movement due to structural changes in non-bony tissue) of the left upper arm, forearm, and hand and with dementia (a progressive disease with marked cognitive loss).

Review of the annual MDS (Minimum Data Set-a required assessment) for resident #40 and dated 4/29/13, identified the resident with a BIMS (Brief Interview for Mental Status) score of 2/15 (indicated severely impaired cognition), experienced physical behaviors 1-3 days of the 7 day assessment, required extensive assistance from 2 staff with bed mobility, transfers, and identified it as somewhat important to the resident to listen to music that he/she liked, go outside to get fresh air when the weather was good, and somewhat important to do his/her favorite activities.

The Activity CAA (Care Area Assessment) did not trigger.

Review of the care plan, dated 5/2/13, revealed the the resident wandered in the facility and rummaged through things frequently. The resident also tried to exit the doors and went into other resident's rooms. At night the resident had disrobed and took all covers and threw them to the floor then try to use the pads on the bed to cover up. The resident also "picked apart" the incontinent brief, grabbed the aides' arms and pushed the aides against the wall resisting care at night. The staff were guided to redirect the

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resident from entering other resident's rooms. The resident wore a wanderguard to notify staff when he/she got close to doors in the hallway. The resident also received Zoloft that he/she took for depression and Seroquel (antipsychotic) for resisting care. The care plan lacked direction to staff on how to provide activities to the resident.

Review of the undated pocket sheets, used as a shortened care plan or "cheat sheets" for the direct care staff to carry with them revealed it did not direct staff on how to provide activities to the resident.

Review of the physician's review of orders, signed on 5/1/13, revealed an order that "Resident may participate in program of physical/social activity as tolerated."

Review of the admission recreation assessment, completed on 6/1/12, revealed the resident enjoyed country music, reading/writing, walk/wheeling outdoors, watching television, gardening and plants, talking or conversation, watching movies, and liked to look at cars. It also identified the resident as involved in activities 1/3 to 2/3 of the time.

Review of the 4/29/13 activity assessment, revealed the staff identified the resident chose not to participate in group activities, participated in independent activities of choice, one on one visits, required assistance to attend activities, was a passive participant (observed, displays inappropriate behaviors in activities, was responsive to one to one programming, was responsive to one to one visits, preferred to be alone, had difficulty in making friends, rarely

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initiated conversations, preferred to stay in his/her room, preferred to be out of room, visited with family and friends, communicated verbally and was able to make needs known.

The activity progress notes dated 4/29/13 revealed (The resident) does not sit still long enough to attend activities. Wanders in wheelchair, attention span is short, enjoyed sitting in his/her recliner in room, watched TV, reads books, magazines, anything with writing on it. Does not understand what is read. Will wander in and out of activity room. No discharge planned.

Review of the care tracker revealed that activity staff documented that the resident went to morning coffee on 4/10 and 5/7 played ball games,
4/9--hydration, reading/writing, watching TV
4/10--hydration, morning news, morning coffee, one on one, watched movie/TV
4/11--one on one, watched movie/TV
4/12--family visit, watched movie, reading/writing
4/16--one on one, movie/TV
4/19--family visit, reading/writing, movie/TV
4/20--family visit, reading/writing, movie/TV
4/22--one on one, reading/writing, movie/TV
4/24--hydration, one on one, movie/TV
4/26--one on one, reading/writing, movie/TV
4/29--special event
4/30--one on one, movie/TV, reading/writing, movie/TV
5/1--one on one with reading/writing, movie/TV, movie/TV
5/2--one on one, movie/TV
5/6--reading/writing, movie/TV
5/7--hydration, played ball games, one on one, reading/writing, movie/TV

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F 248	Continued From page 17 5/8--one on one, reading/writing, movie/TV Of the 50 different activites provided to the resident over 17 days, 18 of them involved movie/TV. On 5/7/13 at 11:22 a.m., observation revealed the resident sat in a recliner in his/her room, in the dark. The weather outside was cloudy with rain, and there was little light coming in the window. The resident leaned over the right side of the recliner, with his/her eyes closed. The television was on a news station. Several observations revealed the resident remained in his/her room until 11:57 a.m., when 2 staff came into the resident's room to assist the resident to the dining room for the noon meal. On 5/7/13 at 1:17 p.m., staff brought the resident back immediately from the dining room to the resident's room and placed the resident in a recliner in his/her room. As the Direct care staff left the room, they left the television on for the resident. Direct care staff E said to leave the door open, as it entertained the resident to watch the people go back and forth in the hallway. On 5/7/13 at 3:58 p.m., observation revealed the resident sat in a recliner in his room. The resident did not move much, but when he/she did, he/she rocked the recliner with his/her foot. The television remained on to a news station. No music played in the room and there were no reading material for the resident. On 5/8/13 at 9:30 a.m., observation revealed the resident sat in a recliner in his/her room. The television was on a news channel, but the	F 248		

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resident did not watch the television. No music played in the room, there were no reading materials for the resident.

On 5/9/13 at 8:30 a.m., observation revealed the resident's spouse sat with the resident in the activity room, where there were other people eating breakfast. The spouse did not attempt to assist the resident to eat.

On 5/9/13 at 9:07 a.m., observation revealed the resident now sat outside on the patio with the spouse.

On 5/7/13 at 12:03 p.m., Direct care staff E stated the resident did not go to many activities because he/she would not stay, he/she attempted to wheel away. Staff E also said they keep the resident's door open because the resident liked to watch the staff walk back and forth in front of his/her room.

On 5/8/13 at 6:25 p.m., Direct care staff M said the resident did not go to any activities in the evenings because the resident wanted to go into other resident rooms, so the staff tried to keep the resident comfortable in his/her recliner. Staff M identified staff turned the TV on for the resident.

On 5/9/13 at 8:22 a.m., Direct care staff B stated he/she did not believe the resident went to activities--he/she has not seen the resident attend them.

On 5/9/13 at 2:43 p.m. Activity staff N stated that he/she did one on one activities with the resident, including reading devotionals with the resident 2-3 times a week, and the spouse visits and took

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F 248	Continued From page 19 him/her to the breakfast this morning and sat with him/her outside and he/she seemed to enjoy that. Staff N stated the resident did not attend group activities because the resident wandered. Staff N identified the small activities that he/she provided to residents with dementia included a "board with all the gadgets" and reading to the resident. Staff N confirmed those activities were not on the activity calendar. On 5/9/13 at 2:51 p.m. Administrative Nurse K stated that activities as a whole are so much better than what they were like just 6 months ago. However, staff K understood the concern with the resident sitting in a room with the television on for company. Review of the facility's undated policy on the Activity Department revealed that "Activity staff will provide one-on-one visits to all residents who choose not to participate in group activities to ensure that all their social needs are met." The facility failed to provide activities of interest, including reading material, walks outside and music, to a confused resident with wandering tendencies.	F 248		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced	F 250		

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by:
The facility census totaled 50 residents with 21 included in the sample. Based on observation, interview, and record review, the facility failed to provide the medically-related social serves for 1 of 4 residents sampled for weight loss. (#16) Resident #16 exhibited signs/symptoms of depression, including weight loss, after the loss of a close friend.

Findings included:

- Review of resident #16's annual MDS (minimum data set) dated 3-4-13 revealed a BIMS (brief interview for mental status) score of 3 indicating the resident had severe cognitive impairment, had no behaviors, did not have signs of depression, had clear speech, and was able to understand others and be understood. The resident required extensive assist of one staff with personal hygiene, dressing, eating, had no weight loss, no swallowing problems, took an antipsychotic for 3 days and an antidepressant for all 7 days of the 7 day look back period. The MDS revealed the resident's weight was 140 pounds.

Review of the cognitive loss CAA (care area assessment) dated 3-5-13 revealed the resident had dementia with behavioral disturbances/paranoia. The resident had depressed moods that were noted by the physician and were treated with Zoloft (an antidepressant) for refusal of care and decreased appetite. The CAA identified the resident's Zoloft was discontinued, but weight loss and increased depressed behaviors increased, so the Zoloft was restarted. The resident took Zoloft daily for depression,

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Depakote (mood stabilizer) for dementia with behaviors, was withdrawn, ate slowly and very little most of the time even with cues. The resident needed staff assistance and encouragement, and showed resistance with meals, care, and medications. He/she had trouble with memory, was confused at times, did come out of room and sat next to a male/female resident in the facility but often sat with eyes closed, and required extensive assistance with ADL's (activities of daily living).

Review of the psychotropic drug use CAA dated 3-5-13 revealed the resident had dementia with behavioral disturbances/paranoia, needed Zoloft daily for depression and was withdrawn the majority of the time.

Review of the care plan for general information dated 8-9-2011 and revised on 3-6-13, revealed the resident enjoyed attending events with a fellow male/female resident and friend. The care plan directed staff to sit them together for events such as music and watching television in the lobby. The care plan identified the resident at times would hit, kick, scratch or spit at staff if they tried to care for the resident and he/she did not want them to. On 3/22/13, the resident's friend passed away. On 3-25-13, the physician discontinued the resident's Zoloft--given for the resident's depressive moods and withdrawn behavior. On 3-29-13, staff discontinued the intervention for staff to have the resident sit with the friend.

Review of the care plan for meals/snacks dated 8-9-2011 and last reviewed on 3-6-13 indicated

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the resident needed cues to eat and was fed by staff depending on mood, was given a shake (supplement) with all meals for increased intake.

Review of the behavior symptoms monitoring from February 2013 through April 2013 revealed the resident refused care for personal hygiene on 2-1-13, and 3-30-13 as well as refused care with personal hygiene, eating, medicine and dressing on 3-5-13.

Review of activities assessment completed on 2-15-13 in comparison to the assessment completed on 12-10-12, revealed the resident had declined in the participation in activities, rarely initiated conversation, did not enjoy small groups, and did not prefer to be out of his/her room. The assessment lacked identification of the resident's decline.

Review of the social service notes dated 3-11-13 revealed a visit with the resident who smiled and gave 1 to 2 word answers with no concerns voiced at that time.

Review of the social service notes dated 3-12-13 revealed the facility had a care plan meeting and would continue the same plan of care. The notes further indicated that social service provided 1 to 1 visits for social and mental stimulation, during the visits the resident had talked about daily seasonal events, family personal needs and social services would continue to visit and keep in touch with family. The social services failed to identify any further psychosocial changes for this resident. The clinical record lacked further evidence of social service involvement when the resident's mood declined. The social service

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notes lacked any monitoring of the resident's depressive moods after 3-20-13 when the physician discontinued the resident's antidepressant, Zoloft, even though the resident had a history of a previously failed attempt at a discontinuation of the medication.

Review of the nurse's notes on 4-25-13 revealed the resident was admitted to a local hospital for acute renal (kidney) failure.

The resident re-admitted to the facility on 4-27-13 from the hospital.

Review of the nurse's notes on 5-9-2013 at 5:20 a.m. revealed the resident passed away.

An observation on 5-7-13 at 11:52 a.m. revealed the resident sat at a table in the dining room, his/her head was hanging downward. The resident was served pureed chicken with gravy, mashed potatoes with cheese, and pureed spinach, a 6 ounce glass of orange juice and 8 ounce glass of water. At 11:56 after attempts from dietary staff to assist the resident with the meal, and the resident would shake his/her head "no" and refused the food and drink, the resident then was removed from the dining area and taken to his/her room and assisted to bed.

On 5-7-13 at 12:16 p.m. in an interview direct care staff I reported the resident had not been eating for at least 2 weeks and he/she refused meals and liquids. Staff reported he/she had another resident friend who passed away recently and the resident had declined since then. Direct care staff I identified the resident's "friend" had passed away at the end of February 2013 or

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beginning of March 2013. Staff I stated "The resident and the friend were very close and if asked they would say they were married to each other." "The resident's friend used to come looking for him/her all the time stating "where's my (resident's name)?" They sat together at the dining table for meals and during activities. The resident would smile when the friend was around. Staff stated "They even took their picture together." Staff pointed to a framed photo of the resident and the friend sitting close together, they both had smiles. Staff I reported the resident would feed himself/herself some of the time when the friend was present at the meal, however, after the friend passed away, there was a noticeable decline in the resident from that time.

On 5-9-13 at 11:28 a.m. in an interview Social Service staff A reported the resident had declined over the last three months, slept for increasing periods of time, and was close to another resident who passed away recently, however, staff A then indicated that due to having dementia the resident would not have remembered the other resident who passed and felt the resident was no more depressed than previously. Staff A reported it was his/her opinion the resident was not depressed due to the other resident passing away. Staff A reported he/she does regularly attend the Quality Assurance meetings and did attend in March 2013 and was made aware of the change in the resident's status as far as refusing meals and the weight loss. Staff A reported not having attended the Quality Assurance meeting in April 2013 due to other appointments, however, did review the meeting notes and was aware the resident continued to have difficulty with refusing meals and weight loss. Staff A verified there were

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no further evaluations for depression performed on this resident and also verified that between the dates of 3-11-13 and 4-29-13 there were no documented 1 to 1 visits with this resident.

On 5-9-13 at 2:33 p.m. in an interview Administrative nursing staff K reported the resident's weight loss and refusal of the meals had been brought up at the Quality Assurance meetings. Other staff had reported the resident had been close to another resident friend who resided at the facility evidenced by them sitting together at meals and for activities. The friend had since passed.

On 5-17-13 at 11:00 a.m., Administrative nursing staff K stated that the facility's process for identifying weight loss was done when Dietary staff D entered the weights into a computer program and received a weight report. This weight report was then utilized at a weekly care plan meeting where several Administrative staff, Consultant NN, and Social Service staff A gather to discuss what interventions had been attempted, which ones did not work, and what else needed to be tried. When asked which staff monitored for an increase in depression symptoms, Nurse K confirmed that it was Administrative Nursing staff R, when he/she completed the MDS. When Nurse R identified an increase in depression, Nurse R then shared that information with Social Service staff A and the resident's physician.

Review of the facility's Mental and Psychosocial policy, dated 8/2011, revealed the following:
1. Upon admission an assessment is completed on residents and the nursing staff addresses

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"mental status". The MDS Coordinator and Social Services during admission review mental/psychosocial needs. They also review resident's mental/psychosocial needs quarterly and upon any significant change. The interdisciplinary team also acknowledges any changes in resident's mental/psychosocial needs together as a team and the nursing home staff will implement care in collaboration with other members of the interdisciplinary team - ranging from the physician (who may need to consider medical issues that are complicit in care needs) to the nursing assistant (who provides the majority of care) - as well as the resident and his/her family members.

2. If it is determined that a resident is depressed, either by staff reporting to charge nurse or th interdisciplinary team, notification will be sent to the physician, one on one visits will be conducted to help identify other measures that might help depression prior to medication changes or additions, and if needed, will ask for psychiatric consult and treat.

3. Social Services will follow up to help address all on-going psychosocial needs.

4. For those residents who have an assessment that does not reveal a mental or psychosocial adjustment difficulty, display a pattern of decreased social adjustment difficulty, display a pattern of decreased social interaction and/or, display increased withdrawn, angry, or depressive behaviors staff will monitor in between assessments using the care tracker tool.

Also, review of the undated Social Service

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F 250	Continued From page 27 Designee expectations from the facility included the following: Conditions to which the facility should respond with social services or referral services: Presence of a chronic disabling medical or psychological condition. Difficulty with personal interaction and socialization skills. Changes in family relationships, living arrangements, and/or resident's condition or functioning. The facility failed to provide the necessary social services to identify and treat a psychological decline in a resident's status, evidenced by weight loss, a refusal to eat, and a decline in social interaction.	F 250		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems;	F 272		

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Continence;
Disease diagnosis and health conditions;
Dental and nutritional status;
Skin conditions;
Activity pursuit;
Medications;
Special treatments and procedures;
Discharge potential;
Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and
Documentation of participation in assessment.

This REQUIREMENT is not met as evidenced by:
The facility had a census of 50 residents with 21 in the sample. Based on observation, interview, and record review, the facility failed to complete a comprehensive assessment to adequately provide care for residents with psychosocial and urinary incontinence needs for residents #16 and #40.

Findings included:

- Review of resident #16's annual MDS (minimum data set) dated 3-4-13 revealed a BIMS (brief interview for mental status) with a score of 3 indicating the resident was severely cognitively impaired, had no behaviors, no mood score, had clear speech was able to understand

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others and be understood, required two person extensive assist with bed mobility, transfers and toilet use, required one person extensive assist with personal hygiene, dressing, walk in room, walk in corridor and eating. was frequently incontinent of bowel and bladder, had no weight loss, no swallowing problems, took an antipsychotic for 3 days and an antipsychotic for 7 days of the 7 day look back period.

Review of the cognitive loss CAA (care area assessment) dated 3-5-13 revealed the resident had dementia, took Zoloft(an antidepressant) daily for depression, was withdrawn, ate slowly and very little most of the time even with cues, needed staff assistance and encouragement. The resident took Depakote(mood stabilizer) for dementia, showed resistance with meals, care and medications, had trouble with memory, was confused at times, did come out of room and sit next to a male/female resident in the facility but often sat with eyes closed, and required extensive assistance with ADL'S(activities of daily living).

Nutrition did not trigger as a CAA on the MDS.

Review of the care plan for meals/snacks dated 8-9-2011 indicated the resident needed cues to eat and was fed by staff depending on mood was given a shake(supplement) with all meals. The care plan was revised on 4-30-13 indicating the resident was only to be in his/her wheelchair for meals. (No other revisions were made to the care plan regarding changes in nutrition)

Review of the nurse's notes dated 2-19-13 at 1:00 p.m. revealed a change in medications which discontinued protonix(proton pump inhibitor).

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Review of the nurse's notes dated 3-10-13 at 8:06 p.m. revealed the resident had brown colored emesis which smelled like chocolate. (Had chocolate shake at the previous evening meal).

Review of the social service notes dated 3-12-13 revealed the facility had a care plan meeting and would continue the same plan of care. The notes further indicated that social service provided 1 to 1 visits for social and mental stimulation, during the visits the resident had talked about daily seasonal events, family personal needs and that social services would continue to visit and keep in touch with family. (No further social service notations were written until 4-29-13)

Review of the nurse's notes dated 3-20-13 at 9:45 a.m. revealed staff reported the resident was not swallowing food and drink but held it in his/her mouth which had progressed during the week. The nurse's note indicated the resident was no more confused than normal. The staff placed a call to the physician to discuss a swallowing evaluation. At 10:30 a.m. the staff had spoken with the physician who had given orders to taper Depakote(mood stabilizer) and Zoloft(antidepressant). (No orders for a swallow evaluation were given)

Review of the dietician notes dated 4-2-13 (not timed) revealed the resident's intake and weight had been decreasing since mid March. The notes further indicated the resident was reluctant to open his/her mouth and at some meals refused any intake at all.

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Review of the nurse's notes dated 4-2-13 at 2:30 p.m. revealed the resident had a significant weight loss over the last month along with tremendous decrease in appetite and had been refusing to eat and drink most times.

Review of the dietician notes dated 4-16-13 (no time listed) revealed the resident was put on "comfort Care" by the physician. The notes indicated the medication changes made on 3-20-13 could have an effect on intake and a dentist appointment was set for May 8, 2013 to check oral status.(8 weeks after identifying the resident was having difficulty chewing and swallowing food) The notes further indicated the resident was started on warm fluids and the foods were to be at either room temperature or lightly warmed, and also provided hot cereal at all meals with pudding and a pureed texture on all hot meals.

Review of the dietician notes dated 4-23-13 (not timed) revealed the resident continued on pureed food and continued to have very little intake. The notes indicated the resident shook his/her head "no" when offered food. The notes further indicated that most of the time and when he/she took a bite of food or drink it ran back out of his/her mouth. The notes indicated it appeared to the staff as if the resident just wanted to be left alone

Review of the nurse's notes dated 4-24-13 at 1:31 p.m. indicated the resident had lab drawn with the results returned and were out of the normal range. The nurse placed a call to the physician and left a message.

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On 4-25-13 the resident was admitted to the hospital for acute renal(kidney) failure.

On 5-9-13 at 5:40 a.m. the resident passed away.

Review of the weekly weights for the month of march 2013 revealed the resident weighed: March 4, 140 lbs(pounds), March 11, 142 lbs, March 18, 131 lbs, March 25, 127 lbs.; a weight loss of 11% over 14 days.

Review of the weekly weights for the month of April 2013 revealed the resident weighed: April 1, 127 lbs, April 8, 128 lbs, April 15, 119 lbs, April 29, 119 lbs.; a weight loss of 6% over 28 days.

Review of the resident's current weight on May 6, 2013 revealed a weight of 110 lbs a total weight loss of 23% over 63 days.

Review of the meal intake logs for the month of March 2013 revealed a meal intake average of 37% with 6 meals refused.

Review of the meal intake logs for the month of April 2013 revealed a meal intake average of 35% with 27 meals refused.

Review of the facility weight policy dated August 2011 revealed the care plan team will meet on Tuesdays to discuss resident weights so resident care can be individualized and problems or needs addressed. The team consists of the dietary supervisor and all department heads, weekly evaluation will be reviewed, nursing staff will call the physician for needed medical intervention, dietitian/dietary department and Director of Nursing is consulted, care plan of the resident will

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be modified as changes occur by the MDS coordinator. The physician will be notified of any significant weight loss of 5% in 30 days, or 10% in 180 days.

On 5-7-13 at 12:16 p.m. in an interview direct care staff I reported the resident had not been eating for at least 2 weeks. The staff reported the resident had a friend who also resided at the facility who had passed away 2 months ago and this resident had begun to decline shortly thereafter. The staff reported the two residents would often sit together for meals and activities.

On 5-9-13 at 12:07 p.m. in an interview dietary staff D reported the resident had another resident friend who encouraged him/her to eat. The resident friend then passed away towards the end of February. The resident began refusing meals and supplements towards the end of February. Staff D further indicated this was brought up in the Quality Assurance meetings on 3-12-13, and each week thereafter. Staff D reported attempts were made in an effort to improve meal intake including a change of location of the dining to be away from other people, room temperature foods and drinks, other staff encouragement with no better results. Staff D confirmed there were no swallow evaluations performed, no discussion for reviewing discontinued medications, discussions towards new medications to improve appetite with no follow through and no changes were made to the resident's care plan.

On 5-9-13 at 11:28 a.m. in an interview Social Service staff A reported the resident has declined over the last three months, slept for increasing periods of time, was close to another resident

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who passed away, Staff A revealed the resident did not remember the other resident who passed and felt the resident was no more depressed than previously. Staff A reported he/she does regularly attend the Quality Assurance meetings and did attend in March 2013 and was made aware of the change in the resident's status as far as refusing meals and the weight loss. Staff A reported not having attended the Quality Assurance meeting in April 2013 due to other appointments, however, did review the meeting notes and was aware the resident continued to have difficulty with refusing meals and weight loss. Staff A verified there were no further evaluations performed on this resident for depression and also verified that between the dates of 3-11-13 and 4-29-13 there were no documented 1 to 1 visits with this resident.

On 5-9-13 at 10:25 a.m., in an interview Administrative nursing staff R reported a significant change MDS was not done for this resident because he/she felt there were not two different areas of ADL'S that had a great enough change to warrant a comprehensive evaluation of this resident. Staff R revealed he/she did attend the Quality Assurance meetings and was aware of the problem with the weight loss and did talk to some staff, but did not read through the nurse's notes and other dietary documentation to decide if there were other areas of concern for this resident.

On 5-9-13 at 11:12 a.m. in an interview Administrative nursing staff K reported the resident's weight loss and refusal of the meals had been brought up at the Quality Assurance meetings, that the resident had been close to another resident residing at the facility and the

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other resident has passed away just prior to the beginning of the decline of this resident. Staff K confirmed there had been medication changes in March, and the physician had not ordered a swallow evaluation after being informed there were problems with swallowing.

The facility failed to perform a comprehensive assessment of this resident for refusal of meals, possible depression, discontinuation of medications causing possible side effects, and failed to investigate the documentation from various departments indicating a significant status change which could have enhanced the residents quality of life.

- Review of the physician's review of orders, signed on 5/1/13, revealed resident #40 had the following diagnoses: hemiplegia (paralysis on one side of the body), joint contracture (chronic loss of joint movement due to structural changes in non-bony tissue) of the left upper arm, forearm, and hand, and dementia (a progressive disease of marked cognitive loss).

Review of the resident's annual MDS (Minimum Data Set-a required assessment) dated 4/29/13, identified the resident with a BIMS (Brief Interview for Mental Status) score of 2/15 (indicated severely impaired cognition), required extensive assistance of 2 staff for bed mobility, transfers, toileting, was frequently incontinent of bowel and bladder, and received no toileting program nor had staff attempted a bladder retraining trial.

Review of the Urinary Incontinence CAA (Care Area Assessment-a further assessment) dated 5/1/13, identified the resident had depression with

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resistance of care. The CAA identified the resident required extensive assistance in all ADL's (Activities of Daily Living), had a history of a stroke, which in turn had caused the resident to have long term hemiplegia to left side. The CAA identified the resident wore incontinent products and staff changed the products as needed, and the staff anticipated the resident's need for toileting due to the resident's cognitive status.

Review of the care plan, dated 5/2/13, revealed the resident required extensive assistance with his/her ADLs, had contractures of his/her left side and the resident could not move his/her left extremities much on his/her own. The care plan also identified the resident as incontinent of bowel and bladder and needed staff to help the resident to the toilet when the resident awoke, before and after all meals, and then before the resident went to bed. It also identified the resident needed to be checked and changed on bed checks at night. The care plan directed staff to apply barrier cream to the resident as needed. Lastly, the care plan directed staff to not place incontinent pads in the wheelchair on the cushion.

Review of the undated pocket sheets, used as a shortened care plan or "cheat sheets" for the direct care staff to carry with them revealed it identified the resident as "occasionally" incontinent and directed the staff to toilet the resident every 2 hours with the assistance of one staff.

Review of the resident's medical record revealed the facility had failed to conduct a further assessment of the resident's personal toileting habits, such as a 3-day toileting diary, to see if

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offering the resident assistance to the toilet every 2 hours was appropriate.

On 5/8/13 at 4:24 p.m., observation revealed Direct care staff PP and Licensed nursing staff O entered the resident's room, and told the resident they planned to stand the resident up and check the resident's brief. Together the two staff attempted to apply a transfer belt to the resident's waist. While the two staff attempted to apply the transfer belt, a third staff, Direct care staff QQ entered the room at 4:28 p.m. to see if he/she could help. Staff PP and Nurse O decided to use a gait belt for transfer, applied the belt, stood the resident and transferred him/her into the wheelchair. Staff QQ asked if the staff had planned to check the resident's brief? Staff PP answered "yes" and propelled the resident to the toilet. Staff QQ told staff PP that the resident did not do so well in the bathroom, but that was ok, they would transfer him/her to the toilet. Together staff PP and QQ transferred the resident from the wheelchair onto the toilet with a gait belt and after removing the resident's wet incontinent brief. After allowing the resident time on the toilet, the staff then assisted the resident to stand. Staff QQ held the resident upright while staff PP provided perineal care. After staff PP provided perineal care and applied a clean brief, staff QQ transferred the resident onto the wheelchair.

On 5/9/13 at 8:35 a.m., Direct care staff I identified that staff checked the resident's brief to see if it needed changed before and after meals, and at bed time. Staff I said the resident did not do so well on the toilet and staff just checked the brief for incontinence.

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F 272	Continued From page 38 On 5/9/13 at 1:45 p.m. Licensed nursing staff J described the resident as dependent on staff for toileting needs and incontinent of bladder. Nurse J stated staff were to check and change the resident before and after meals, at bedtime and throughout the night. On 5/9/13 at 2:12 p.m. Licensed nursing staff C identified staff were to toilet the resident every 2 hours, but especially before and after meals and at bed time. On 5/9/13 at 2:51 p.m. Administrative Nurse K shared that the facility had identified in their QAPI (Quality Assurance and Performance Improvement) program that they needed to do a better job at developing toileting plans. Nurse K said that they were going to start doing the indepth assessments like 3 day voiding patterns later this month. Nurse K agreed that the staff should be clear on what is expected on the resident's toileting program and the staff should all be doing the same thing. The facility failed to thoroughly assess a resident's incontinence status to develop an individualized toileting plan for a resident that experienced urinary incontinence.	F 272		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the	F 274		

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resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)

This REQUIREMENT is not met as evidenced by:
The facility had a total census of 50 residents with 21 sampled. Based on interview and record review, the facility failed to determine that there had been a significant change in the physical or mental condition of resident #16.

Findings included:

- Review of the quarterly MDS dated 12-10-12 revealed resident #16 had a BIMS score of 3 indicating severe cognitive impairment, no behaviors, a mood score of 1, required extensive assist of two staff for bed mobility, transfers, and toilet use, required extensive assist of one staff for walk in room, dressing, eating, personal hygiene. had no weight loss, no swallowing problems, took an antianxiety and antidepressant for 7 of the 7 day look back period.

Review of resident annual MDS (minimum data set) dated 3-4-13 revealed a BIMS (brief interview for mental status) with a score of 3 indicating the resident was severely cognitively impaired, had no behaviors, no mood score, had clear speech was able to understand others and be understood, required two person extensive assist with bed mobility, transfers and toilet use,

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required one person extensive assist with personal hygiene, dressing, walk in room, walk in corridor and eating. was frequently incontinent of bowel and bladder, had no weight loss, no swallowing problems, took an antipsychotic for 3 days and an antipsychotic for 7 days of the 7 day look back period.

Review of the cognitive loss CAA (care area assessment) dated 3-5-13 revealed the resident had dementia, took Zoloft(an antidepressant) daily for depression, was withdrawn, ate slowly and very little most of the time even with cues, needed staff assistance and encouragement. The resident took Depakote(mood stabilizer) for dementia, showed resistance with meals, care and medications, had trouble with memory, was confused at times, did come out of room and sit next to a male/female resident in the facility but often sat with eyes closed, and required extensive assistance with ADL'S(activities of daily living).

Nutrition did not trigger as a CAA on the MDS.

Review of the care plan for meals/snacks dated 8-9-2011 indicated the resident needed cues to eat and was fed by staff depending on mood was given a shake(supplement) with all meals. The care plan was revised on 4-30-13 indicating the resident was only to be in his/her wheelchair for meals. (No other revisions were made to the care plan regarding changes in nutrition)

Review of the nurse's notes dated 2-19-13 at 1:00 p.m. revealed a change in medications which discontinued Protonix(proton pump inhibitor).

Review of the nurse's notes dated 3-10-13 at

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8:06 p.m. revealed the resident had brown colored emesis which smelled like chocolate. (Had chocolate shake at the previous evening meal.

Review of the social service notes dated 3-12-13 revealed the facility had a care plan meeting and would continue the same plan of care. The notes further indicated that social service provided 1 to 1 visits for social and mental stimulation, during the visits the resident had talked about daily seasonal events, family personal needs and that social services would continue to visit and keep in touch with family. (No further social service notations were written until 4-29-13)

Review of the nurse's notes dated 3-20-13 at 9:45 a.m. revealed staff reported the resident was not swallowing food and drink but was holding it in his/her mouth which had progressively worsened during the week. The note indicated the resident was no more confused than normal. Staff placed a call to the physician to discuss a swallowing evaluation. At 10:30 a.m. the staff had spoken with the physician who gave orders to taper Depakote(mood stabilizer) and Zoloft(antidepressant).(No swallow evaluation was ordered)

Review of the dietician notes dated 4-2-13 (not timed) revealed the resident's intake and weight had been decreasing since mid March. The notes further indicate the resident was reluctant to open his/her mouth and at some meals refused any intake at all.

Review of the nurse's notes dated 4-2-13 at 2:30 p.m. revealed the resident had a significant

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weight loss over the last month along with tremendous decrease in appetite and refused to eat and drink most times.

Review of the dietician notes dated 4-16-13 (no time listed) revealed the resident was put on "comfort Care" by the physician. The notes indicated the medication changes made on 3-20-13 could have an effect on intake and a dentist appointment was set for May 8, 2013 to check oral status.(8 weeks after identifying the resident was having difficulty chewing and swallowing food) The notes further indicated the resident was started on warm fluids and the foods were to be at either room temperature or lightly warmed, and also provided hot cereal at all meals with pudding and a pureed texture on all hot meals.

Review of the dietician notes dated 4-23-13 (not timed) revealed the resident continued on pureed food and continued to have very little intake. The notes indicated the resident shook his/her head "no" when offered food. The notes further indicated that most of the time and when he/she took a bite of food or drink it ran back out of his/her mouth. The notes indicated it appeared to the staff as if the resident just wanted to be left alone

Review of the nurse's notes dated 4-24-13 at 1:31 p.m. indicated the resident had lab drawn with the results out of the normal range. The nurse placed a call to the physician and left a message.

On 4-25-13 the resident was sent to a local hospital for acute renal(kidney) failure.

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F 274	Continued From page 43 On 5-9-2013 at 5:40 a.m. the resident passed away. Review of the weekly weights for the month of march 2013 revealed the resident weighed: March 4, 140 lbs(pounds), March 11, 142 lbs, March 18, 131 lbs, March 25, 127 lbs.; a weight loss of 11% over 14 days. Review of the weekly weights for the month of April 2013 revealed the resident weighed: April 1, 127 lbs, April 8, 128 lbs, April 15, 119 lbs, April 29, 119 lbs.; a weight loss of 6% over 28 days. Review of the resident's current weight on May 6, 2013 revealed a weight of 110 lbs. Calculated weight loss percentage over the last 63 days was 22.54% with a total weight loss of 32 pounds. Review of the meal intake logs for the month of March 2013 revealed a meal intake average of 37% with 6 meals refused. Review of the meal intake logs for the month of April 2013 revealed a meal intake average of 35% with 27 meals refused. Review of the facility weight policy dated August 2011 revealed the care plan team will meet on Tuesdays to discuss resident weights so resident care can be individualized and problems or needs addressed. The team consists of the dietary supervisor and all department heads, weekly evaluation will be reviewed, nursing staff will call the physician for needed medical intervention, dietitian/dietary department and Director of	F 274		

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Nursing is consulted, care plan of the resident will be modified as changes occur by the MDS coordinator. The physician will be notified of any significant weight loss of 5% in 30 days, or 10% in 180 days.

On 5-7-13 at 12:16 p.m. in an interview direct care staff I reported the resident had not been eating for at least 2 weeks. The staff reported the resident had a friend who also resided at the facility who had passed away 2 months ago and this resident had begun to decline shortly thereafter. The staff reported the two residents would often sit together for meals and activities.

On 5-9-13 at 10:25 a.m., in an interview Administrative nursing staff R reported a significant change MDS was not done for this resident because he/she felt there were not two different areas of ADL'S that had a great enough change to warrant a comprehensive evaluation of this resident. Staff R revealed he/she did attend the Quality Assurance meetings and was aware of the problem with the weight loss and did talk to some staff, but did not read through the nurse's notes and other dietary documentation to decide if there were other areas of concern for this resident.

On 5-9-13 at 2:33 p.m. in an interview Administrative nursing staff K reported the resident's weight loss and refusal of the meals had been brought up at the Quality Assurance meetings. Other staff had reported the resident had been close to another resident friend who resided at the facility evidenced by them sitting together at meals and for activities and the other resident had passed away. Staff K confirmed

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there had been medication changes in March, and the physician had not ordered a swallow evaluation after being informed there were problems with swallowing.

On 5-9-13 at 11:28 a.m. in an interview Social Service staff A reported the resident has declined over the last three months, slept for increasing periods of time, was close to another resident who passed away, Staff A revealed the resident did not remember the other resident who passed and felt the resident was no more depressed than previously. Staff A reported he/she does regularly attend the Quality Assurance meetings and did attend in March 2013 and was made aware of the change in the resident's status as far as refusing meals and the weight loss. Staff A reported not having attended the Quality Assurance meeting in April 2013 due to other appointments, however, did review the meeting notes and was aware the resident continued to have difficulty with refusing meals and weight loss. Staff A verified there were no further evaluations performed on this resident for depression and also verified that between the dates of 3-11-13 and 4-29-13 there were no documented 1 to 1 visits with this resident.

On 5-9-13 at 12:07 p.m. in an interview dietary staff D reported the resident had another resident friend who encouraged him/her to eat. The resident friend then passed away towards the end of February. The resident began refusing meals and supplements towards the end of February. Staff D further indicated this was brought up in the Quality Assurance meetings on 3-12-13, and each week thereafter. Staff D reported attempts were made in an effort to improve meal intake including a change of location of the dining to be

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F 274	Continued From page 46 away from other people, room temperature foods and drinks, other staff encouragement with no better results. Staff D confirmed there were no swallow evaluations performed, no discussion for reviewing discontinued medications, discussions towards new medications to improve appetite with no follow through and no changes were made to the resident's care plan. The facility failed to perform a significant change comprehensive assessment for this resident after establishing the resident had problems with refusal of meals, possible depression, discontinuation of medications, the facility also failed to investigate the documentation from various departments indicating a significant status change. By conducting a thorough investigation of the resident's change in condition/status the facility could have prevented a severe decline in the quality of life of resident #16.	F 274		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under	F 279		

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§483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:
The facility census totaled 50 residents with 21 included in the sample. Based on observation, interview and record review, the facility failed to develop comprehensive care plans that dealt with activities, nutrition, positioning, pressure ulcers, skin conditions, and unnecessary medications for 6 of 21 sampled residents. (#26, #59, #40, #51, #14, and #5)

Findings included:

- Review of the physician's review of orders for resident #40, signed on 5/1/13, revealed the resident had the following diagnoses: Left-sided hemiplegia (paralysis on the left side), joint contracture (chronic loss of joint movement due to structural changes in non-bony tissue) of the left upper arm, forearm, and hand.

Review of the annual MDS (Minimum Data Set-a required assessment) dated 4/29/13, identified the resident with a BIMS (Brief Interview for Mental Status) score of 2/15 (indicated severely impaired cognition), required the extensive assistance of 2 staff for bed mobility, transfers, and was not stable and could not stabilize without staff assistance when moving from seated to standing position, moving on and off toilet, surface-to-surface transfers, had skin tears and

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had applications of ointments/medications other than to feet.

Review of the Pressure Ulcer CAA (Care Area Assessment-a further assessment) dated 5/1/13 revealed that the resident required extensive assistance from one staff for ADL's (Activities of Daily Living). It identified the resident had a previous stroke which left the resident with long term hemiplegia to the resident's left side. The CAA lacked mention of any other skin issues, such as fragile skin that resulted in frequent skin tears, or bruising.

Review of the care plan, dated 5/2/13, revealed the resident required extensive assistance with his/her ADL's (Activities of Daily Living) and directed staff to pick out the resident's clothes and dress him/her. The resident's spouse requested the resident wear shoes on both feet. It also identified the resident had contractures of his/her left side and the resident could not move his/her left extremities much on his/her own. Lastly, the care plan guided staff to place the resident in the recliner during the day when not in the dining room. The care plan did not identify if the resident had tendencies to lean or directed staff to monitor the resident's body alignment.

On 5/6/13 at 10:55 a.m., observation revealed the resident sat in a recliner in his/her room. The resident appeared asleep. The resident lay slumped over to the right side of the recliner, with the right hand lying on the floor and the resident's head dangling over the side of the recliner. Two different direct care staff walked past the resident's room, but did not enter the room to reposition the resident.

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On 5/7/13 at 12:03 p.m., Direct care staff E stated that the resident required help from staff to reposition, although he/she can wiggle quite easily in the chair. Staff E agreed the resident had a tendency to lean toward the right, but it was because of the stroke the resident had.

On 5/9/13 at 8:22 a.m., Direct care staff B stated that the resident needed help to sit right in the chair, but when he/she did, then the resident would scoot down so he/she very rarely sat square in any chair.

On 5/9/13 at 2:30 p.m. Administrative Nursing staff K stated that he/she knew the resident did not maintain good posture while in the chair, but it was because the resident would fidget and move about in the chair, and then the resident also had a tendency to lean because of his/her stroke. Nurse K confirmed the care plan should address the resident's tendencies and how staff were to address them.

Review of the facility's Care Plan Policy, dated 8/11, revealed that the facility would develop an initial care plan within 14 days of the resident's admission into the facility and would be done according to triggers off the MDS 3.0 and needs noted by staff, family, and physicians.

The facility failed to develop a care plan that addressed the leaning habits of a resident and how staff were to address these tendencies.

- Review of resident #5's physician's orders, signed on 5/6/13, identified the resident with the following diagnoses: irritable bowel syndrome (a

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disorder that leads to abdominal pain and cramping and changes in bowel movements), stress incontinence (involuntary urination due to pressure on abdomen) constipation, diabetes mellitus, depressive disorder (a disorder characterized by persistent sadness or melancholy) and congestive heart failure (disease where the heart does not function properly).

Review of the Significant change MDS (Minimum Data Set-a required assessment) dated 3/18/13, revealed the resident had a BIMS (Brief Interview for Mental Status) score of 12/15 (indicated moderately impaired cognition), did not show any signs/symptoms of depression, had behavioral symptoms not directed toward others 1-3 days of the 7 day assessment period, frequently incontinent of urine that staff did not attempt a trial of a toileting program to relieve, and with a diagnosis of diabetes mellitus.

Review of the Psychotropic Medication Use CAA (Care Area Assessment-a further assessment) dated 3/22/13, revealed the physician gave an order for the resident to receive diazepam (an antianxiety) 10 mg (milligrams) po (by mouth) q (every) HS (bedtime) for treatment of neuropathy (a disease of the peripheral nerves). The CAA identified the resident had diabetes mellitus. The CAA also identified the resident had a diagnosis of neuropathy the CAA identified could be related to the diabetes mellitus. Staff documented in the CAA that the plan included for staff to administer the diazepam for neuropathy because the resident did not exhibit any significant side effects.

Review of the medication care plan, dated 1/2/13,

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revealed that since 3/22/13, the resident had taken Valium (an antianxiety medication) for treatment of the resident's neuropathy. The care plan also identified the resident took the following medications: Anusol HC-1 (medication for hemorrhoids), Aspirin, Diazepam, Glipizide (for diabetes mellitus), Januvia (for diabetes mellitus), Levothyroxine (thyroid hormone replacement included a black box warning for not to be used for weight loss), miraLax (encouraged routine bowel movements), Omeprazole (for gastric upset), Sertraline (antidepressant- Black box warning for clinical worsening and suicide risk), Tums (for stomach upset), Tylenol and Vesicare (used for urinary incontinence). The care plan also identified on 4/4/13 that the resident took Zoloft (an antidepressant) routinely for depression with episodes of tearful outbursts. The medication care plan, attached to the care plan, addressed the medications with black box warnings. The care plan failed to identify the indications of use for each medication, so staff knew what to watch for.

On 5/7/13 at 3:10 p.m., observation of Direct care staff F and OO revealed the staff assisted the resident to the bathroom. Staff F and OO used a mechanical lift and removed the resident's incontinent brief. Observation of the brief revealed it was wet. Staff F and OO provided perineal care, then placed a clean brief on the resident, then propelled the resident still in the mechanical lift, out of the bathroom to the bed and assisted the resident to lie down before the evening meal. Staff F and OO were very polite with the resident. .

On 5/7/13 at 12:03 p.m., Direct care staff E

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identified the resident really does have behaviors, he/she tries to stand up by himself/herself and then he/she falls. Staff E did not know what kinds of medicine the resident received "I am just a CNA (Certified Nurse's Aide), I am not a medication aide or anything like that."

On 5/9/13 at 12:51 p.m. Licensed nursing staff J stated he/she did not really know about why the resident took Omeprazole, other than the resident was alert enough to let the staff know. As for the diazepam, staff J did not know why that the resident used neuropathy as a diagnosis--"it doesn't sound like a good diagnosis." Staff J confirmed that staff do not routinely ask the resident about pain in the legs--the staff wait until the resident said something about pain first. Staff J confirmed that the resident did not complaining of pain that staff J was aware of. Staff J looked in the nurse's notes and did not see anything in the nurses notes documented about pain, either.

On 5/9/13 at 2:51 p.m. Administrative nurse K stated the diazepam being used for neuropathy does sound odd and someone probably should have called about that. Nurse K admitted there have been some problems with documentation that they have identified and therefore they have recently started to assigning like 5 or 6 residents to one nurse and the nurse will go through the chart, talk with the resident the family and the doctor and make sure the information is in the chart, so hopefully things like this will be addressed. Nurse K identified that the facility had made attempts at dose reductions, but tried to complete all recommendations at once for all the residents in the facility on psychotropics to ask for

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dose reductions. Nurse K identified they overwhelmed the physicians with requests and the physicians did not respond timely. Nurse K stated the facility had to send several letters to the physicians to remind them a response was needed. Nurse K identified that was why the dose reductions were not attempted in a timely fashion.

Review of the facility's Care Plan Policy, dated 8/11, revealed that the facility would develop an initial care plan within 14 days of the resident's admission into the facility and would be done according to triggers off the MDS 3.0 and needs noted by staff, family, and physicians.

The facility failed to develop a medication care plan that directed staff to monitor for the use of an antidepressant, an antianxiety, a medication used for incontinence, and a medication used to prevent night-time heartburn.

- Review of resident #26's signed physician order sheet dated 4-3-13 included the following diagnoses: anxiety state (a mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), dementia (progressive mental disorder characterized by failing memory, confusion) with behaviors, and depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, melancholy, dejection, worthlessness, emptiness and hopelessness).

Review of the admission MDS (Minimum Data Set 3.0, a required assessment) dated 9-16-12 revealed a BIMS (Brief Interview for Mental Status) score of 3 indicating severe cognitive

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deficit. The MDS revealed it was very important for the resident to do his/her favorite activities and participate in religious services, and somewhat important to do things with groups of people. It revealed the resident required extensive assistance of 1 staff with all ADL's (Activities of Daily Living) except for limited assistance of 1 with walking and locomotion.

Review of the Care Area Triggers revealed activities and psychosocial services did not trigger for further assessment.

Review of the Cognitive CAA (Care Area Assessment) associated with the 9-16-12 MDS revealed the resident had dementia with anxiety and usually understood others. It revealed the resident could also usually make him/herself understood but mumbled and spoke very quietly.

Review of the care plan last reviewed on 3-6-13 under the general information directed staff to invite the resident to activities and he/she would join as he/she chose. The care plan lacked any further mention of activities the resident liked, such as: bus rides, walking/wheeling outside, music, or other identified interests.

Review of the North Hall 2 ADL(Activities of Daily Living) sheet revealed it lacked any information regarding activities of interest the resident had.

Review of the recreation assessment dated 9-6-12 revealed the resident's current interest included cards and other games, crafts, exercise, music, spiritual activities, and walk/wheeling outdoors.

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Review of the activity notes dated 12-6-12 revealed the resident enjoyed sing-a-longs, music, kickball, and exercise. The resident also enjoyed reading mail, the local newspaper, and strolls about the facility.

During an interview on 5-7-13 at 3:13 p.m. direct care staff II reported the resident had care plans in their rooms that staff use to direct care and also had a "cheat sheet" to use that told them what to do for the residents.

During an interview on 5-9-13 at 7:37 a.m. direct care staff N and staff Y reported they incorporate things the resident liked to do with the monthly activities. Staff N reported an assessment was completed when residents first came in and then tried to encourage them to attend the activities. Staff N reported all residents were invited if able to do some of the things done in the facility. Staff N & staff Y reported the resident took a lot of one-on-one supervision, "loved kickball", and music or sing-a-long.

During an interview on 5-9-13 at 8:23 a.m. administrative staff R reported he/she usually tried to get the specific likes in the care plan. Staff R reported that he/she read the notes, asked about likes, and tried to put that information in the top section of the care plan, including activities the resident liked. Staff R reported he/she read the whole entire chart and talked to the aides about the resident. When asked specifically about the resident and the likes that were in the recreational assessment, staff R reported they had just started to incorporate resident likes in the care plan.

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During an interview on 5-7-13 at 4:14 p.m. Administrative nurse K reported the ADL sheets were updated with care plans and anytime there were any changes in care. He/she reported they had not been updated for a couple of weeks because staff had not given him/her any changes that needed made.

Review of the Care Plan Policy revised on 8/11 revealed the purpose was to capture an "Accurate reflection of resident daily needs/cares." and the "Initial care plan is done according to triggers and needs noted by staff, family, and physician within 14 days."

The facility failed to develop and implement a comprehensive care plan for resident #26 that included activities the resident might like to participate in.

- Review of resident #59's signed physician order sheet dated 4-11-13 included the following diagnoses: Dementia, (progressive mental disorder characterized by failing memory, confusion) with behaviors/ agitation, and insomnia (inability to sleep).

Review of the admission MDS (Minimum Data Set 3.0, a required assessment) dated 4-22-12 revealed a BIMS score of 2, severe cognitive impairment. It also revealed the resident had difficulty focusing, was easily distracted, and had disorganized thinking that fluctuated throughout the day. It also revealed the resident had physical and verbal behaviors toward others, and inappropriate behaviors not directed at others, 1-3 days out of past 7. It revealed the resident's

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preferences for participating in favorite activities or religious events were not very important to him/her. It revealed the resident required extensive assistance of 1 for all cares except for walking in room required limited assistance and used a wheelchair for mobility. It revealed the resident was not steady but able to stabilize without staff assistance with transfer, turning around or moving on and off the toilet.

Review of the Visual Function CAA (Care Area Assessment) dated 4-23-13 revealed the resident had macular degeneration, and was considered to be blind. Staff pushed the resident in the halls and needed extensive assistance of staff with daily cares.

Review of the Psychosocial CAA dated 4-23-13 revealed the resident resisted assistance, reported he/she was depressed. It indicated the resident took Remeron for depression and Nortriptyline for insomnia and behaviors. The MDS also revealed the resident stated he/she did not have anything that he/she really liked to do except sit there and listen to people talk and interact but did get a soda and really enjoyed it.

Review of the Behavioral CAA dated 4-23-13 revealed the resident had used Ativan as needed for increased anxiety along with the Remeron for depression and Nortriptyline for insomnia and behaviors.

Review of the Fall CAA dated 4-24-13 revealed the resident was unsteady when he/she stood up and had been unsteady at home as well. It included the resident took Remeron for depression, nortriptyline for insomnia and

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behaviors, and ativan for increased anxiety. It revealed the resident had some hearing deficit and had macular degeneration and was considered blind. The CAA also revealed the resident had 3 falls when attempting to stand from wheelchair.

Review of the care plan dated 4-14-13 revealed the resident used to be a farmer and liked to sit and listen to people talk, and enjoyed getting a soda. It directed staff to take the resident to activities and such so that he/she could listen to the people visit. The care plan lacked any information regarding other activities the resident might enjoy. The care plan also included direction for the resident to have a pressure reducing pad in it but lacked any direction regarding the use of foot pedals to help with proper positioning in the wheelchair or using a pillow or other device to help the resident maintain proper positioning. The care plan also included a concern of poor sleep patterns (slept only 30 min to 1 hour at a time). It indicated the resident received Nortriptyline and it had been increased due to insomnia and inappropriate behaviors. The care plan lacked any non-pharmacological interventions to help in promoting sleep.

Review of the North Hall 1 ADL (Activities of Daily Living) sheet revealed it lacked activity interest of sitting and listening to others, lacked interventions to promote sleep, and lacked interventions to assist with maintaining proper positioning when in the wheelchair.

During an interview on 5-7-13 at 3:13 p.m. direct care staff II reported the residents had a copy of

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the care plans in their rooms that staff use to direct care and also had a "cheat sheet" to use that told them what to do for the residents.

During an interview on 5-9-13 at 8:23 a.m. Administrative staff R reported he/she usually tried to get the specific likes in the care plan. Staff R reported that he/she read the notes, asked about likes, and tried to put that information in the top section of the care plan, including activities the resident liked. Staff R reported he/she read the entire chart, and talked to the aides about the resident, and had just started putting individual likes and things in the care plan.

During an interview on 5-7-13 at 4:14 p.m. Administrative nurse K reported he/she updated the ADL sheets with the care plans and anytime there were any changes in care. He/she reported they had not been updated for a couple of weeks because staff had not given him/her any changes that needed made.

During an interview on 5-9-13 at 3:29 p.m. Administrative nursing staff K reported he/she would expect for staff to be monitoring a resident for symptoms of insomnia who received a medication for insomnia and providing other things to assist the resident to sleep. He/she also reported staff was working on trying to develop more individualized care plans according to what the resident likes.

The facility failed to develop a comprehensive care plan for resident #59 that included activities of interest, interventions to help in promoting sleep, and interventions to help the resident

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maintain proper positioning in the wheelchair.

- Review of resident #14's annual MDS (minimum data set) dated 2/25/13 revealed a BIMS (brief interview for mental status) with a score of 11 (moderately impaired). The resident identified at risk for skin breakdown with none at that time. The resident had a pressure reducing device in the chair. Staff were applying ointments other than to the residents feet.

Review of the quarterly MDS dated 12/3/12 revealed a BIMS score of 11 (moderately impaired). The resident received ointments used for other than feet.

Review of the Skin condition CAA (care area assessment) dated 2/25/13 did not trigger resident had no pressure ulcers.

Review of the care plan with a date of 2/27/13 revealed the resident had a risk of skin breakdown. There was no plan for the skin rash on the right cheek and no mention of how to treat the area. The facility failed to initiate a care plan for the recurring rash on the residents face and for the treatment and the prevention.

Review of the admission History and Physical dated on 4/1/12 revealed that the resident has a rash on his/her right cheek.

On 3/23/13 review of the nurses notes revealed that, the resident's skin was warm, pink, with a reddened area to the right cheek. The resident reported that the area itches sometimes so when it does he/she scratched it.

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4/6/13 8:00 a.m., review of the nurses notes revealed that the reddened spot on the right cheek area has remained the same for a long time.

On 5/7/13 at 11:45 a.m., observation revealed the resident in his/her room seated in the wheel chair. The resident had a lighter red area, and then a darker red area on the right cheek. The resident picked at the area and tried to pick off a harder area that almost scabbed over.

On 5/7/13 at 11:45 a.m., asked the resident what happened to his/her face? Asked if it itched or if it was painful, he/she replied that it occasionally itched, but not now. The resident also thought that the area was the result of the dry weather.

On 5/8/13 at 7:35 a.m., direct care staff GG revealed the resident has had the redness a long time because he/she picks on the area

On 5/9/13 at 8:20 a.m., direct care staff HH revealed the resident picked at the area on the face. The area healed and then came back. The resident would not leave it alone.

On 5/8/13 at 3:15 a.m., licensed nursing staff O revealed the resident had that area when he/she started working here in January 2013. Nursing staff O revealed he/she knew they put TAO (triple antibiotic ointment) on the area, but the resident continued to picked at the area, it would heal then came right back.

On 5/9/13 at 10:40 a.m. interview with licensed nursing staff O revealed the resident had this rash off and on since he/she had been here for 3

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years it would heal then came back. TAO was put on the area on the right cheek but since the resident picked at it the area continues to come back.

Review of the Care plan Policy reviewed and revised 8/2011 revealed that:
a. Upon admission an interim care is put into place by the admitting nurse.
d. Care Plan is reviewed again and revised with in 92 days by MDS coordinator
g. The care plan may be reviewed and revised as needed at any time.

The facility failed to develop a care plan that directed the staff in the care and treatment of the reddened area on resident #14's right cheek.

- Review of the admission MDS dated 11-26-12 revealed resident #51 had a BIMS score of 00 indicating the resident was severely cognitively impaired. The resident had unclear speech, sometimes made self understood and sometimes understood others, required extensive assist of two staff for transfers, toilet use, and extensive assist of one staff for bed mobility, walk in room, dressing, eating, personal hygiene. The resident had taken an antipsychotic for 2 days of the 7 day look back period. The MDS indicated the resident was not at risk for developing pressure ulcers.

Review of the quarterly MDS(minimum data set) dated 2-18-13 revealed the resident had a BIMS(brief interview for mental status) score of 00 indicating the resident was severely cognitively impaired. The resident required extensive assistance of two staff for transfers, toilet use, and one staff for bed mobility, locomotion,

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dressing, eating, and personal hygiene, took a diuretic for 7 days, an antibiotic for 5 days, and an antipsychotic for 2 days of the 7 day look back period. The MDS further indicated the resident was not at risk for pressure ulcers but did indicate the resident had developed an infection of the foot and used a pressure relieving device for the wheel chair.

No Care Area Assessment(CAA) dated 11-26-12 triggered for pressure ulcers.

Review of the care plan dated 12-18-12 directed staff to use a heel boot on the right foot for pressure relief.

Review of the discharge summary from a local hospital dated 11-23-12 revealed no wounds to right heel.

Review of the nursing assessment dated 11-25-12 revealed no skin issues to both heels.

Review of the weekly skin assessment dated 12-5-12 revealed the resident had a large blister to the right heel which staff monitored and no special equipment was used.

Review of the Nurse's notes dated 12-14-12 at 9:15 a.m. indicated the resident was lying in the bed with staff dressing and changing a brief. The resident was not responsive verbally at that time but did open eyes earlier at 6:30 a.m. when spoken to. The resident did, however, show facial grimacing when staff manipulated the right foot. The note indicated the resident was a full assist with ADL's and did not attempt to assist staff with dressing. The nurse note indicated the resident

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did not support any of his/her own weight for transfer but did have facial grimacing and moaning. After being placed in the wheelchair the resident's eyes remained closed.

Review of the Nurse's notes dated 12-14-1:45 p.m. the resident was taken to the clinic for a follow up appointment with family present. The resident became less responsive at 12:40 p.m. that day by just mumbling with his/her eyes closed as well as requiring staff assistance with the noon meal and required two staff for transfer due to not supporting his/her own weight.

Review of the physician's orders dated 12-14-12 directed the staff to have strict pressure relief to right heel.

Review of the weekly skin assessment dated 12-28-12 revealed a large soft black spot on bottom of right heel and the use of a pressure relieving boot.

An observation on 5-7-13 at 11:21 a.m. of the resident seated in a recliner chair, awake and alert, with the foot rest in the up position and no pressure relieving devices visible, he/she was speaking to the staff but not making clear sentences, was also making attempts to sit up and get out of the recliner chair after the direct care staff told him/her it was time to get up. The staff placed a lift belt around the resident's waist, secured it with the snap buckles and attached a strap to the sit to stand lift. The staff were giving the resident simple instructions to pick up his/her feet and put them on the lift foot pedal as well as asking the resident to hold the side arms of the lift which the resident was not able to follow

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commands on the first instruction and it took a few times of repeating by the staff to get him/her to follow the instructions. The resident was then taken to the toilet to void. While sitting on the toilet the resident continuously reached and grabbed for different objects including the toilet paper roll, the wall grab bar, the emergency call light string. After voiding and having a bowel movement, the staff performed peri care and place a clean dry brief on the resident. The staff continued to dress the resident in slacks and calf length socks with non-skid booties on the feet. An observation of the resident's skin condition revealed intact skin in the buttocks and peri area and on the right heel a nickel sized thick yellow flaky scab with pink intact skin around the heel area.

An observation on 5-8-13 at 8:10 a.m. revealed three staff assisted the alert resident to walk in the hall using a supportive walker, a gait belt and the wheelchair behind. The resident walked at least 50 feet then started to slow down and stop. The staff then asked if he/she was ready to sit down. At that time the resident sat in his/her own wheelchair with the pedals turned to the side and began to self propel the wheelchair in the hall way.

In an interview on 5-7-13 at 11:40 a.m. direct staff E reported the resident had a fall in November and broke the left elbow, when he/she returned from the hospital, he/she had an arm sling which decreased mobility and was unable to assist with bearing weight, dressing and daily cares due to decreased cognitive function which was very different from his/her behavior before the accident. After the staff had the doctor adjust the

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F 279	Continued From page 66 resident's medications, he/she was able to do more now and can help with simple things, stand with some support for balance, make needs known most of the time. The staff reported the resident had a boot on the right foot after he/she came back to the facility but was unsure of how the foot sore happened. The staff was aware the resident was to keep pressure off the right heel by using the boot. In an interview on 5-9-13 at 8:27 a.m. direct care staff KK reported when the resident returned from the hospital in November 2012, he/she was not very active and would stare off in space a lot. Staff KK stated the resident just sat there without talking much or reacting to people around. Staff did report the resident developing a blister on the right heel but was unsure of how it got there and did remember the resident having to wear a black heel boot for a long time. In a interview on 5-9-13 at 8:36 a.m. direct care staff I reported the resident came to the facility and was somewhat independent, could feed himself/herself and assist with ADL's, however, after returning from the hospital in November 2012, the resident had become a total care needing extensive assistance from two staff for all ADL's including eating. The staff recalled the resident developing a problem with the right foot and having to wear a black boot on it for a long time with it just recently being removed. The facility failed to develop and revise the care plan due to the changes in the resident's condition after a fractured arm.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280		

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F 280	Continued From page 67 The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: The facility census totaled 50 residents with 21 included in the sample. Based on observation, interview, and record review, the facility failed to revise the care plans for 3 sampled residents to address the changes or continued needs for falls, monitoring of dialysis shunt site, education on the continued refusal of a recommended diet, the need to encourage fluids, and a decline in urinary incontinence. (#5, #28, and #40) Findings included: - Review of resident #28's review of orders,	F 280		

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signed by the physician on 5/1/13, revealed the resident had the following diagnoses: chronic renal disease, anemia in ESRD (End Stage Renal Disease), and end stage renal disease.

Review of the quarterly MDS (Minimum Data Set-a required assessment), dated 2/18/13, identified the resident with a BIMS (Brief Interview for Mental Status) score of 15/15 (indicated little to no cognitive impairment), and received dialysis treatments while a resident.

Review of the care plan, dated 2/25/13, identified the dialysis center that the resident attended recommended the resident receive a modified renal diet that included low salt, low potassium, and low phosphorus. The care plan also identified the resident had renal failure, had fluctuating weights due to edema (swelling) in the resident's legs and dialysis treatments. It identified the resident was supposed to avoid salt in his/her diet, but identified the resident chose what he/she wanted to eat and usually did not follow the physician's recommendations regarding meals. The care plan identified the Registered Dietician provided the resident education regarding the diet on 9/6/12. The care plan identified the dialysis center monitored the resident's laboratory test results and vital signs as needed when the resident went to the dialysis center. The care plan identified the nursing staff had explained the risks of not receiving the dialysis treatments 3 days a week as ordered, but the resident still decided not to go at times, usually on days with bad weather. Lastly, the care plan identified the resident had a dialysis port in the right arm, and instructed staff to not use the resident's right arm to draw blood from,

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take blood pressures or pulling to help the resident up.

Review of the dietary progress notes revealed they lacked any documented evidence of education provided to the resident about dietary choices.

On 5/6/13 at 2:53 p.m., observation revealed the resident sat in a recliner in his/her room, watching television. He/she wore a short-sleeved shirt. Observation revealed he/she had a fistula on the upper right arm that was covered in plastic tape, over two small, white gauze squares. The fistula stood up from the resident's arm high and observation revealed one could see the blood pulsing through the fistula. The sight did not evidence redness or swelling, and the resident said it did not hurt.

On 5/8/13 at 6:30 p.m., Social Service staff A identified that he/she had taken the resident to dialysis that day. Staff A confirmed the resident wanted to stop and eat at fast food restaurants on the way home on the days the resident went to dialysis. Staff A stated the resident chose the restaurant and that day had chosen McDonalds. Staff A said he/she hated McDonalds, but that was what the resident wanted, so they stopped there to eat. Earlier in the week, they had stopped at Pizza Hut and gotten a pizza. The resident ate the leftovers for lunch the next day.

On 5/9/13 at 8:22 a.m., Direct care staff B stated he/she did not know if the resident was restricted on fluid intake, or if the resident received a specialized diet. Staff B stated that the resident could make his/her own decisions.

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F 280	Continued From page 70 On 5/9/13 at 8:40 a.m., Licensed Nurse C identified the resident went to dialysis on Monday, Wednesday, and Fridays and that the resident's shunt in the resident's right arm, but lacked knowledge whereon the arm the shunt was positioned. When asked if staff C ever reviewed it the site, or palpated it, staff C reported he/she did not ever look at the site, that was something that the dialysis center did. Nurse C also stated that he/she did not know if the resident received a specialized diet or not, but that the resident made his/her own decisions. Nurse C did not know if the resident followed the recommended diet or not and did not provide any education to the resident about dietary intake. On 5/9/13 at 9:00 a.m. Dietary staff D identified the resident's diet was "mostly self-directed." Staff D identified that together with Consultant NN, staff D go over the laboratory results with the resident. Staff D identified the resident had received dialysis services long enough to know how to manipulate the laboratory readings--"(The resident) used to tell me he/she only 'had to be good' (meaning watch what he/she ate) 4 days before the blood draw." Staff D identified the resident as very independent and made his/her own decisions. The Registered Dietician at the dialysis unit sent over a request for the resident to follow a modified renal diet when the resident first started going to the unit for dialysis, but he/she refused. When asked who provided the ongoing education on the risks of refusing that type of diet, staff D identified the education was provided by Consultant NN and that Consultant NN documented the education in the chart in the dietary notes.	F 280		

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On 5/9/13 at 10:08 a.m., Administrative Nurse K stated that when the resident first came to the facility, Nurse K sent a Licensed Nurse along with the resident to the dialysis unit to ask what specific care the facility was supposed to provide. The dialysis center had told the nurse that the facility staff did not have to do anything at all. Nurse K agreed that staff should provide education to the resident regarding the dietary needs and it should be in the care plan.

The facility failed to revise the care plan of a resident who received dialysis services to address the needs of monitoring the fistula site and providing the ongoing education about following the recommended specialized diet.

- Review of resident #5's physician's orders, signed on 5/6/13, identified the resident with the following diagnoses: irritable bowel syndrome (a disorder that leads to abdominal pain and cramping and changes in bowel movements), stress incontinence (involuntary urination due to pressure on abdomen), and constipation. .

Review of the Admission MDS (Minimum Data Set-a required assessment) dated 12/19/12, identified the resident with a BIMS (Brief Interview for Mental Status) score of 15/15 (indicated little to no cognitive impairment), required limited assist from staff with bed mobility, transfers, and toileting, and with occasional urinary incontinence (less than 7 episodes per week).

Review of the resident's significant change MDS (Minimum Data Set-a required assessment) dated 3/18/13, identified the resident with a BIMS

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(Brief Interview for Mental Status) score of 12/15 (indicated moderately impaired cognition), required extensive assistance from one staff with bed mobility, transfers, toileting, and frequently incontinent of urine. (More than 7 episodes of urinary incontinence pre week).

Review of the Urinary Incontinence and Indwelling Catheter CAA (Care Area Assessment-a further assessment) dated 3/21/13 revealed the resident required limited to extensive assistance from staff with toileting. It identified the resident experienced some dribbling of urine and wore incontinent products, had staff assist him/her at times with perineal care and changing of incontinence products. The CAA also noted the resident had a history of two surgeries on his/her bladder and had recently seen the physician where the resident described he/she would stand up and urine would flow right out. The CAA did not identify the reason for the decline in the resident's urinary incontinence.

Review of the care plan, dated 1/2/13, identified the resident had stress incontinence, wore incontinent briefs and had a long history of problems with incontinence, as the resident had two surgeries on his/her bladder. The care plan identified the resident had seen a urologist (physician that specializes in the urinary tract system) for his/her incontinence, and on 12/12/12 the urologist ordered new medications to try and see if it helped with the incontinence. The resident required help to change the incontinence products, and needed staff assistance with perineal care. The care plan identified the resident called frequently to use the toilet during the night. On 2/15/13, staff revised the care plan

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and directed staff to offer to help the resident to the toilet every 2 hours. The care plan lacked any further revisions to address if the new intervention assisted the resident with the increased urinary incontinence.

Review of the undated pocket sheets, used as a shortened care plan or "cheat sheets" for the direct care staff to carry with them revealed it identified the resident as "occasionally" incontinent and directed the staff to toilet the resident every 2 hours with the assistance of one staff.

On 5/7/13 at 3:10 p.m., observation of Direct care staff F and OO revealed the staff assisted the resident to the bathroom. Staff F and OO used a mechanical lift and removed the resident's incontinent brief. Observation of the brief revealed it was wet. Staff F and OO provided perineal care, then placed a clean brief on the resident, then propelled the resident still in the mechanical lift, out of the bathroom to the bed and assisted the resident to lie down before the evening meal. Staff F and OO were very polite with the resident.

On 5/9/13 at 8:35 a.m., Direct care staff I stated the resident did experienced some urinary incontinence, but it wasn't all the time. Staff I said that the resident would ring to go to the bathroom, so Staff I took the resident whenever he/she rang.

On 5/9/13 at 12:51 p.m., Licensed Nursing staff C said the resident's leg strength had started to decline when the resident moved to the facility, and since then the resident now used a wheelchair for mobility and staff used a lift to help

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with transfers. When asked why the resident now experienced more urinary incontinence than when the resident moved into the facility, Nurse C said it was because the resident went independently to the toilet and now he/she needs staff assistance, so he/she just sits in the wheelchair and wets.

On 5/9/13 at 2:51 p.m. Administrative Nurse K shared that the facility had identified in their QAPI (Quality Assurance and Performance Improvement) program that they needed to do a better job at developing toileting plans. Nurse K said that they were going to start doing the indepth assessments like 3 day voiding patterns later this month. As for resident #5 in particular, Nurse K stated that the resident had developed a UTI (Urinary Tract Infection) last month and they identified that and got the resident started on an antibiotic, then the resident developed shingles, so Nurse K really felt like that once they get the resident healthy, the incontinence will get better. Agreed that the staff should be clear on what is expected on the resident's toileting program and the staff should all be doing the same thing.

Review of the facility's Care Plan Policy, dated 8/11, revealed the care plans are reviewed and revised within 92 days by the MDS Coordinator, and that the Care Plan may be reviewed and revised as needed at any time. It lacked guidance on the process for identification of the resident's changes in needs in between the quarterly MDS reviews, or to whom to report those changes to.

The facility failed to review and revise a resident's care plan after the resident experienced an

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increase in urinary incontinence.

- Review of resident #5's physician's orders, signed on 5/6/13, identified the resident with the following diagnoses: irritable bowel syndrome (a disorder that leads to abdominal pain and cramping and changes in bowel movements), stress incontinence (involuntary urination due to pressure on abdomen), and constipation.

Review of the Admission MDS (Minimum Data Set-a required assessment) dated 12/19/12, identified the resident with a BIMS (Brief Interview for Mental Status) score of 15/15 (indicated little to no cognitive impairment), required limited assist with bed mobility, transfers, and had falls in the 2 months prior to the admission to the facility.

Review of the resident's Significant change MDS (Minimum Data Set-a required assessment) dated 3/18/13, identified the resident with a BIMS (Brief Interview for Mental Status) score of 12/15 (indicated moderately impaired cognition), required the extensive assistance of one staff for bed mobility, transfers, was unsteady and only able to stabilize with staff assistance when moving from seated to standing positions, walking, turning around, moving on/off toilet, and surface to surface transfers. The assessment also identified the resident had falls since admitting to the facility, 2 without injury and 2 with injury.

Review of the Fall CAA (Care Area Assessment-a further assessment) dated 3/21/13 revealed the resident had frequent falls when he/she lived at home with his/her spouse. The CAA identified the resident had fallen frequently since admission

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to the facility because the resident was not compliant with calling for assistance. The CAA identified that staff had not determined the reason for not calling yet as forgetfulness or the resident just chose not to call for assistance from staff. It identified the resident had a decrease in physical abilities and still tried to do things independently without calling for help. The CAA identified and described the resident's 8 falls, 4 of which occurred with urinary incontinence or in/on the way to the bathroom, and 3 of which happened when the resident attempted to get out of bed independently. The CAA identified the resident took 10 mg (milligrams) of Valium (an antianxiety) medication every evening for neuropathy (disease of the peripheral nerves). The CAA also identified the resident had an unsteady gait with a "sway" when the resident walked. Lastly, the CAA identified the resident at very high risk for falls and at that time the resident had alarms to notify staff when the resident got up unattended. The CAA identified the resident continued to get up unattended. The CAA identified staff developed interventions to try to prevent the resident from falling.

Review of the care plan, dated 1/2/13, revealed that staff noted the resident had gotten up on his/her own without calling for help. The resident required reminding to call for help due to a history of many falls in the month prior to the admission to the nursing facility. The resident could get upset when told by staff to not ambulate independently because he/she remembered ambulating independently when he/she lived in his/her own home.

On 3/22/13, staff added the following information:

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"(The resident) (takes) Valium (an antianxiety) at night for treatment of his/her neuropathy.
On 3/30/13, staff added "fall at sink standing unassisted to reach tooth paste. Staff to put toothpaste (and) tooth brush beside sink when assisting ready for evening meal within reach."
On 2/22/13, staff added: "Fall--chair pad alarm applied at all times."
2/23/13, staff added: "Fall--back up brakes checked for functioning."

Review of the undated pocket sheets, used as a shortened care plan or "cheat sheets" for the direct care staff to carry with them revealed it did not identify the resident as a fall risk, or identify what staff are to do to prevent falls.

On 5/7/13 at 3:10 p.m., observation revealed Direct care staff F and OO assisted the resident to the bathroom then back to bed with the use of a mechanical lift. Observation revealed the staff did not place any type of pad alarm under the resident when the staff assisted the resident into bed.

On 5/9/13 at 8:35 a.m., Direct care staff I stated the resident had falls, mainly on the evening shift or night shift. Staff I identified when the resident moved into the facility, the resident was able to stand and walk "some", but since then he/she had slowly lost that ability and he/she now used a wheelchair all the time and it was getting to the point that staff had to use a mechanical lift to help him/her to stand during transfer. Staff I further identified the resident did not remember that he/she could no longer stand independently, so he/she would try to stand up out of the bed. Staff I stated staff reminded the resident frequently that

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he/she now needed help to transfer, and also the resident had a pad alarm that staff used all the time.

On 5/9/13 at 12:51 p.m. Licensed nursing staff J stated the staff tried to remind the resident to call for help and that did not seem to work. Staff now use the alarm and that seemed to have helped because the resident had not had nearly the falls he/she used to. Nurse J could not remember the kind or type of alarm the resident used, or when it was to be on.

On 5/9/13 at 2:51 p.m. Administrative Nurse K stated that he/she understood the confusion about the pad alarm and he/she planned to make sure it was more clear in the care plan the type of alarm and when it was to be used for the resident. Nurse K did not know if the resident should be using a pad alarm while in bed, or just while the resident sat in the chair. Nurse K agreed that the fall investigations should identify the newly developed intervention, as well as the care plan. Nurse K also agreed that the investigation should address if staff had the previously developed interventions in place at the time of the fall to determine if they were effective.

Review of the facility's undated policy on Fall Tracking Program revealed the following:
"c. Resident's name will remain in the 3-day book until fall charting is completed. MDS Coordinator, one nurse and ADON (Assistant Director of Nurses)/DON (Director of Nurses) will evaluate whether resident fall risk level should change. The Charge Nurse on duty at the time of the fall will determine a new/different intervention to prevent further falls. This intervention will be

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posted on the care plan in the chart and in the room if appropriate. All staff will help with implementation of POC (Plan of Care) to prevent further falls."

The facility failed to review and revise the care plan to develop and implement new interventions after each fall for a resident with frequent falls.

- Review of the physician's review of orders for resident #40, signed on 5/1/13, revealed the resident had the following diagnoses: Left-sided hemiplegia (paralysis on the left side), joint contracture (chronic loss of joint movement due to structural changes in non-bony tissue) of the left upper arm, forearm, and hand, and dementia (progressive disease with marked cognitive loss).

Review of the resident's annual MDS (Minimum Data Set-a required assessment) dated 4/29/13, identified the resident with a BIMS (Brief Interview for Mental Status) score of 2/15 (indicated severely impaired cognition), required the extensive assistance from one staff with eating, experienced a weight gain of 5% or more in the last month or 10% or more in the last 6 months, and received a mechanical soft diet. The assessment also did not identify the resident with hydration issues.

Review of the Nutritional CAA (Care Area Assessment-a further assessment) dated 5/1/13, revealed the resident had a previous stroke which in return has caused the resident long term hemiplegia to the left side. It also identified staff assisted the resident to eat, but could independently eat bites and drinks but often does not get much accomplished because of the

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resident's short attention span. Staff served the resident a mechanical soft to aide in chewing and swallowing. Staff must transfer the resident into a regular dining room chair at meals because of the resident's wandering habits and short attention span. The staff must anticipate the resident's needs, and the resident had a significant weight gain in the last 30 days. The CAA also identified the resident usually left 25% or more of the meals uneaten.

Review of the care plan, dated 5/2/13, revealed directions to staff to transfer the resident into a dining room chair, to get the resident's silverware out and cut up the resident's food. It also identified the resident used a divided plate for eating. It also directed staff to serve the resident a mechanical soft or pureed diet, cue the resident to eat, but the resident frequently needed assistance with eating. The care plan also directed staff to encourage the resident to eat more at meals, offer the resident snacks when he/she was in the halls to supplement the dietary intake, that the resident had a lactose intolerance, took protein shots in juice and soy milk in the evening for extra supplementation. Lastly, the care plan identified the resident's food likes as fruit, hard cheese, raw carrots, hamburger, fish, orange sherbet, and tea. The resident's dislikes included chicken, eggs, cottage cheese, sour cream, or yogurt. The care plan did not identify any issues with hydration, other than the lactose intolerance.

Review of the undated pocket sheets, used as a shortened care plan or "cheat sheets" for the direct care staff to carry with them directed staff to transfer the resident to a regular chair while

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eating and to cue and assist the resident to eat. How the resident ate depended on how he/she was. It also identified the resident wore a clothing protector. It did not identify any issues with hydration.

Review of a physician's progress note, dated 12/18/12 and timed 3:00 p.m. revealed an order for staff to "Push oral fluids" and to obtain some laboratory blood work.

On 5/7/13 at 11:57 a.m., 2 nurse aides, Direct care staff E and LL entered the resident's room and transferred the resident from the recliner into the wheelchair. Once the staff had positioned the resident into the wheelchair with a foot rest, staff LL propelled the resident to the dining room without offering a drink. Staff LL then transferred the resident into a regular chair in the dining room and left the resident. No glasses of fluid sat on the table for the resident to drink.

On 5/7/13 at 12:09 p.m., observation revealed staff served the resident an 8 oz (ounce) glass of grape juice, and an 8 oz glass of ice water with the meal. The staff handed the glass of juice to the resident and the resident drank all of the juice, so then staff offered the resident the ice water. The resident did not drink much of the ice water.

On 5/7/13 at 12:47 p.m., observation revealed the resident had not drank much of the ice water, so the staff went and got an 8 oz container of chocolate soy milk and placed it in a 12 oz glass. The staff came back with it and the resident immediately started drink it.

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On 5/7/13 at 1:07 p.m., observation revealed the resident had drank all of the juice and the milk, but very little of the ice water, or 540 cc of fluid. Staff assisted the resident back to his/her room.

On 5/9/13 at 8:35 a.m. Direct care staff I stated that the resident received a pureed diet and was not on any other type of special diet for fluids, including encouraging fluids, because the resident drank fluids well. Staff I stated that the resident received all his/her fluids at meals and when he/she went to activities. Staff I identified that fluids given in between meals were given out usually during activities. Staff I described encouraging fluids meant bringing extra juices to the resident between meals and it is usually for those that don't like to drink or it's hard to get them to drink.

On 5/9/13 at 2:08 p.m., Licensed nursing staff C stated the resident was not not on any kind of fluid restriction, and that staff gave the resident "lots" of fluids at meals. Nurse C stated that if he/she saw the resident with a dry mouth, then he/she would tell the staff to push fluids at meal times, but since the resident drinks well, staff don't really need to do that. Nurse C identified the staff give the resident drinks from the water pitcher whenever they are in the room with the resident as it is now, so Nurse C knew the resident received plenty of fluids.

On 5/9/13 at 2:51 p.m. Administrative Nurse K stated he/she expected the staff to give drinks out of the water pitchers when the aides are in the rooms working with the residents. Nurse K also identified that encouraging or pushing fluids meant staff were to bring extra fluids between

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F 280	Continued From page 83 meals to the residents and offer them more frequently throughout the day. Nurse K stated he/she was not aware that the doctor wanted the staff to push fluids for the resident. The facility failed to review and revise a care plan to include an order from the physician to push fluids for a resident at risk for dehydration.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: The facility census totaled 50 residents with 21 included in the sample. Based on observation, interview, and record review, the facility failed to provide the necessary care and services in monitoring a dialysis access site for 1 sampled resident #28, maintaining proper positioning for 2 sampled residents with tendencies to lean while seated (#40 and #59) and protecting the fragile skin of 1 sampled resident. (#40) Findings included: - Review of resident #28's review of orders, signed by the physician on 5/1/13, revealed the resident had the following diagnoses: chronic renal disease, anemia in ESRD (End Stage Renal	F 309		

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Disease), and end stage renal disease.

Review of the quarterly MDS (Minimum Data Set-a required assessment), dated 2/18/13, identified the resident with a BIMS (Brief Interview for Mental Status) score of 15/15 (indicated little to no cognitive impairment), and received dialysis treatments while a resident.

Review of the care plan, dated 2/25/13, identified the dialysis center that the resident attended recommended the resident receive a modified renal diet that included low salt, low potassium, and low phosphorus. The care plan also identified the resident had renal failure, had fluctuating weights due to edema (swelling) in the resident's legs and dialysis treatments. It identified the resident was supposed to avoid salt in his/her diet, but identified the resident chose what he/she wanted to eat and usually did not follow the physician's recommendations regarding meals. The care plan identified the Registered Dietician provided the resident education regarding the diet on 9/6/12. The care plan identified the dialysis center monitored the resident's laboratory test results and vital signs as needed when the resident went to the dialysis center. The care plan identified the nursing staff had explained the risks of not receiving the dialysis treatments 3 days a week as ordered, but the resident still decided not to go at times, usually on days with bad weather. Lastly, the care plan identified the resident had a dialysis port in the right arm, and instructed staff to not use the resident's right arm to draw blood from, take blood pressures or pulling to help the resident up.

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Review of a dietary progress note, dated 2/4/13, identified Consultant NN had identified the resident made his/her own meal choices and had told Consultant NN that he/she was limiting his cheese intake due to a high phosphorous blood level. The note identified the resident as capable of making his/her own food choices but would also say he/she is going to eat what he/she wants. The note identified the need to "Continue to encourage healthy choices for meals" It lacked who was supposed to encourage the healthy choices for this resident.

On 5/6/13, Dietary staff D wrote a note that identified the resident directed his/her own diet. Staff D documented the resident frequently skipped meals and had a "stash" of snacks in his/her room. It also identified the resident made good choices in regards to his/her nutritional health and did not stray from his/her goals.

On 5/6/13 at 2:53 p.m., observation revealed the resident sat in a recliner in his/her room, watching television. He/she wore a short-sleeved shirt. Observation revealed he/she had a fistula on the upper right arm that was covered in plastic tape, over two small, white gauze squares. The fistula stood up from the resident's arm high and observation revealed one could see the blood pulsing through the fistula. The sight did not evidence redness or swelling, and the resident said it did not hurt.

On 5/7/13 at: 11:52 a.m., observation revealed the resident sat in an electric wheelchair in the dining room, eating 2 pieces of hamburger pizza independently. The resident stated that it was leftover from the day before, when he/she went to

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dialysis and they stopped at Pizza Hut on their way home.

On 5/8/13 at 7:15 a.m., observation revealed the resident prepared to go to dialysis. The resident stood up out of an electric wheelchair and independently transferred into another wheelchair, where a Social Service staff A then prepared to push the resident outside into a van. The Staff A stated they were headed to a local city, where they go every Monday, Wednesday and Friday. The resident said he/she was looking forward to going out to lunch more. When asked where he/she was going for lunch, he/she said "We don't know, we go to whatever sounds good at the time." The staff member said that they go out to eat every day he/she is in (the city).

On 5/6/13 at 2:53 p.m., the resident stated the fistula has never bled out once he/she had gotten back to the facility. The resident said that it had lost it's "plug" a couple of times in the dialysis unit before they sent him/her home, but never at the facility. The resident denied being on a specialized diet--he/she said that he/she knew what to do. The resident stated that he/she got his/her blood drawn at the dialysis unit and that occasionally they will tell him/her that his/her potassium is high and he/she needs to watch it, but he/she usually just cut down on the dark pop. He/she stated he/she did not really drink a lot of it anyway, but he/she would cut it out of his/her diet completely when his/her potassium was high.

On 5/8/13 at 6:30 p.m., Social service staff A stated that the resident wanted to stop at McDonalds for lunch after dialysis. Staff A stated he/she hated McDonalds, but that was what the

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resident wanted, so they stopped there to eat.

On 5/9/13 at 8:22 a.m. Direct care staff B reported the resident went to dialysis on Mondays, Wednesdays, and Fridays. Staff B said the resident left early in the morning and returned right at shift change, or around 2:00 in the afternoon. Staff B identified the resident's shunt was located in the resident's right arm and Staff B said he/she could not take the resident's blood pressure in that arm. Staff B reported that if he/she saw the resident bleeding from the site, he/she would get the nurse just as soon as possible and try to stop the bleeding. Staff B lacked knowledge in regard to the resident's diet.

On 5/9/13 at 9:00 a.m. Dietary staff D identified the resident's diet as mostly self-directed. Staff D identified the dialysis center drew laboratory tests on the resident at the first of the month and then sent the report to the facility, where Consultant NN went over the reports with the resident. The dialysis Registered Dietician had sent over a recommendation for modified renal diet when the resident first went started going to this dialysis center, but the resident refused. We make suggestions, Consultant NN provides the training and education of the diet to the resident. It should be documented how often Consultant NN provides education to the resident.

On 5/9/13 at 8:40 a.m., Licensed Nurse C identified the resident went to dialysis on Monday, Wednesday, and Fridays and that the resident's shunt in the resident's right arm, but lacked knowledge whereon the arm the shunt was positioned. When asked if staff C ever reviewed it the site, or palpated it, staff C reported he/she

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did not ever look at the site, that was something that the dialysis center did. Staff C did not know if the resident received a specialized diet, or if the physician or dialysis center had recommended a special diet for the resident.

On 5/9/13 at 10:08 a.m., Administrative Nurse K stated that when the resident first came to the facility, Nurse K sent a Licensed Nurse along with the resident to the dialysis unit to ask what specific care the facility was supposed to provide. The dialysis center had told the nurse that the facility staff did not have to do anything at all. Nurse K agreed that the nurses needed to at least look at the shunt site and see if it looked reddened, or swollen, or if it was oozing blood to head off problems later. Nurse K said that the facility did not have a policy on dialysis, but she/he would be making one that day.

The facility failed to provide the necessary care and services in regard to monitoring the shunt site and failed to provide on-going education regarding the suggested modified renal diet for a resident on dialysis.

- Review of the physician's review of orders for resident #40, signed on 5/1/13, revealed the resident had the following diagnoses: Left-sided hemiplegia (paralysis on the left side), joint contracture (chronic loss of joint movement due to structural changes in non-bony tissue) of the left upper arm, forearm, and hand.

Review of the annual MDS (Minimum Data Set-a required assessment) dated 4/29/13, identified the resident with a BIMS (Brief Interview for Mental Status) score of 2/15 (indicated severely

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impaired cognition), required the extensive assistance of 2 staff for bed mobility, transfers, and was not stable and could not stabilize without staff assistance when moving from seated to standing position, moving on and off toilet, surface-to-surface transfers, had skin tears and had applications of ointments/medications other than to feet.

Review of the Pressure Ulcer CAA (Care Area Assessment-a further assessment) dated 5/1/13 revealed that the resident required extensive assistance from one staff for ADL's (Activities of Daily Living). It identified the resident had a previous stroke which left the resident with long term hemiplegia to the resident's left side. The CAA lacked mention of any other skin issues, such as fragile skin that resulted in frequent skin tears, or bruising.

Review of the care plan, dated 5/2/13, revealed the resident required extensive assistance with his/her ADL's (Activities of Daily Living) and directed staff to pick out the resident's clothes and dress him/her. The resident's spouse requested the resident wear shoes on both feet. It also identified the resident had contractures of his/her left side and the resident could not move his/her left extremities much on his/her own. Staff were to apply arm protectors daily for more protection of his/her arms, although the resident frequently removed the arm protectors as the staff placed them. It identified the resident had surgery the to release his/her left arm and fingers from contracting. Lastly, the care plan guided staff to place the resident in the recliner during the day when not in the dining room.

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Review of the undated pocket sheets, used as a shortened care plan or "cheat sheets" for the direct care staff to carry with them revealed it did not mention the resident's tendency to lean, nor did it direct staff to monitor the resident's body alignment. The cheat sheets did identify the resident wore arm protectors.

Review of the physician's review of orders, signed on 5/1/13, revealed the following PROM (Passive Range of Motion) & Strength Exercises 3-7 times a week, PROM left shoulder, elbow, wrist, fingers, Thumb 3-7 x week as tolerated.

On 5/6/13 at 10:55 a.m., observation revealed the resident sat in a recliner in his/her room. The resident appeared asleep. The resident lay slumped over to the right side of the recliner, with the right hand lying on the floor and the resident's head dangling over the side of the recliner. Two different direct care staff walked past the resident's room, but did not enter the room to reposition the resident. The resident wore a short-sleeved shirt and did not have on any type of arm protector. Located on the bedside table next to the resident's left side sat an elbow protector.

On 5/7/13 at 11:22 a.m., observation revealed the resident sat in a recliner in his/her room, in the dark. The weather outside was cloudy with rain, and there was little light coming in the window. The resident leaned over the right side of the recliner, with his/her eyes closed. There were no pillows provided for comfort for the resident, and staff did not stop in to reposition the resident's body alignment. The resident wore a short-sleeved shirt and did not have on any kind

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of arm protectors. Observation of the resident's left elbow revealed a small area covered in dry skin, like a scab.

On 5/7/13 at 11:57 a.m., 2 nurse aides, Direct care staff E and LL entered the resident's room, transferred the resident out of the recliner and into a wheelchair. Neither staff E or LL attempted or offered to put on arm protectors on the resident. Direct care staff LL then propelled the resident to the dining room where he/she then transferred the resident to a regular chair in the dining room, then left the resident in the chair. The resident slumped to the right side and staff LL did not try to reposition the resident or use pillows to make sure the resident sat in good alignment.

On 5/7/13 at 1:17 p.m., Direct care staff E and LL transferred the resident to the recliner out of the wheelchair. After the transfer, Direct care staff E identified the resident received skin tears on the elbows when he/she bumped the elbow on the arm of the wheelchair. Staff E then demonstrated on the wheelchair where the resident torn his/her skin. Staff E said "That's how he/she gets them (skin tears)--on the wheelchair right where his/her arm hits the wheelchair." When asked if the resident wore skin protectors, staff E said no.

On 5/8/13 at 7:15 a.m., observation revealed the resident sat in the recliner in his/her room, leaning over to the right side of the recliner, resting.

Observation on 5/8/13 from 6:29 p.m. revealed the resident sat in the dining room at a table in the corner. The resident sat in a regular chair,

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but leaned severely to the right. Nursing staff F that assisted another resident did not look or assist the resident. At 6:32 dietary staff removed the food from in front of the resident, but did not ask the nursing staff to reposition the resident. At 6:30 p.m., observation revealed Licensed nurse MM went into the dining room, but did not look at the resident, but helped another resident. Nurse MM then left the dining room. At 6:36 p.m., nurse MM came back into the dining room and spoke with Direct care staff F, who said that he/she needed help with resident #40. Nurse MM did not assist staff F, but started to help another resident to eat. Staff F left the dining room and returned at 6:39 p.m. with Licensed Nurse X. Together nurse X and staff F transferred the resident into a wheelchair, then staff F propelled the resident back to his/her room.

On 5/7/13 at 12:03 p.m., Direct care staff E stated that the resident required help from staff to reposition, although he/she can wiggle quite easily in the chair. Staff E agreed the resident had a tendency to lean toward the right, but it was because of the stroke the resident had.

On 5/9/13 at 8:22 a.m., Direct care staff B stated that the resident needed help to sit right in the chair, but when he/she did, then the resident would scoot down so he/she very rarely sat square in any chair.

On 5/9/13 at 8:35 a.m., Direct care staff I stated that the resident had a tendency to scoot all over in chairs, and the staff were constantly having to reposition him/her because he/she fidgets quite a bit and then he/she wound up not sitting right. When staff saw the resident not sitting in the

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chair right, they always reposition him/her so that he/she was sitting right.

On 5/8/13 at 6:47 p.m., Licensed nursing staff O identified that the resident did get weak and would lean to the right side, but nurse O thought that it was due to the resident's stroke, so the staff just needed to reposition the resident whenever they saw him/her not sitting straight.

On 5/9/13 at 2:17 p.m., Licensed Nursing staff C stated that the resident had a tendency to move around in both the wheelchair and the recliner, so trying to make sure he/she sat straight in the chair was hard, but the staff tried to reposition him/her as frequently as they could. Nurse C also stated that the resident usually bumped his/her elbow and would get skin tears. When that happened, staff treated the skin tears daily so they did not become infected.

On 5/9/13 at 2:30 p.m. Administrative Nursing staff K stated that he/she knew the resident did not maintain good posture while in the chair, but it was because the resident would fidget and move about in the chair, and then the resident also had a tendency to lean because of his/her stroke. Nurse K also confirmed staff were to place cloth arm protectors on the resident because the resident bumped that left elbow a lot and got skin tears. However, Nurse K stated the resident would frequently remove them when staff did put them on. When told that staff never attempted to place arm protectors on the resident, Nurse K smiled and nodded.

Review of the facility's Wheelchair policy, dated 8/11, revealed PT (Physical Therapy) will also

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evaluate for positioning periodically for all assistive/positioning devices and these devices will be appropriately placed in the wheelchair when the resident is in the wheelchair.

The facility staff failed to provide the necessary care and services to ensure a resident with a tendency to lean received the positioning help from staff to maintain good body alignment. Also, the facility failed to follow the plan and provide arm protectors to this resident with fragile skin and prone for skin tears.

- Review of resident #59's signed physician order sheet dated 4-11-13 included the following diagnoses: Dementia, (progressive mental disorder characterized by failing memory, confusion) with behaviors/ agitation, and insomnia (inability to sleep).

Review of the admission MDS (Minimum Data Set 3.0, a required assessment) dated 4-22-12 revealed a BIMS (Brief Interview for Mental Status) score of 2 that indicated severe cognitive impairment. It also revealed the resident had difficulty focusing, easily distracted, and had disorganized thinking that fluctuated throughout the day. The MDS revealed the resident had physical and verbal behaviors toward others, which put the resident at risk for physical illness or injury, and behaviors not directed at others 1-3 days out of past 7. It also revealed the resident had a fall in the past 6 months prior to admission to the facility and had 2 falls since admission. It revealed the resident required extensive assistance of 1 staff for all cares except for walking in room required limited assistance and used a wheelchair for mobility. It revealed the

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resident was not steady but able to stabilize without staff assistance with transfer, turning around, or moving on and off the toilet. The resident used wheelchair for mobility. It also revealed the resident had moderately impaired vision in that he/she could not read newspaper headlines, but could identify objects.

Review of the Visual Function CAA (Care Area Assessment) dated 4-23-13 revealed the resident had macular degeneration and noted to be blind. The resident needed extensive assistance with eating and dressing and also needed assistance with mobility in the halls. The resident had glasses but they were left at home because the resident refused to wear them because they did not help.

Review of the Fall CAA dated 4-24-13 revealed the resident was unsteady when he/she stood up and had been very unsteady prior to admission and fell at home. It included the resident received Remeron for depression, Nortriptyline for insomnia and behaviors, and Ativan as needed for increased anxiety. The resident also wanted to get up and use the toilet and had occasional urinary incontinence. The MDS also revealed the resident had fallen to knees 3 times when attempting to get out of wheelchair. It revealed the resident had macular degeneration and was considered blind and also had a hearing deficit.

Review of the care plan dated 4-14-13 revealed the resident used a wheelchair for mobility with a pressure reducing pad. The care plan lacked direction for staff to use foot pedals to help with proper positioning in the wheelchair or using a pillow or other device to help the resident

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maintain proper positioning to keep the resident's feet from dragging on the floor.

Observation on 5-7-13 at 1:49 p.m. revealed licensed nurse Z and direct care staff AA went into the resident's room and staff Z assisted the resident to sit up on the side of the bed. Both staff then assisted the resident to transfer into the wheelchair using a gait belt and then placed a pillow in the left side of the chair due to the resident leaning to the left. The wheelchair did not have foot pedals on and the resident's feet touched the floor. The resident wore non-skid socks and as staff pushed the resident up the hall his/her right foot slid along the floor all the way to the dining room.

Observation on 5-7-13 at 2:45 p.m. revealed staff assisted the resident back to his/her room from the dining room. The resident sat in the wheelchair without a cushion in it, wore non-skid socks and had his/her left foot crossed over the right foot, and the right foot slid on the floor all the way to his/her room.

Observation on 5-8-13 at 11:25 a.m. revealed direct care staff AA pushed the resident back to room from the dining room table. The resident sat in his/her wheelchair with a cushion in it and the resident's feet dangled from the chair and did not reach the floor.

During an interview on 5-7-13 at 1:12 p.m. direct care staff AA reported staff had to watch him/her when in the wheelchair because he/she would lean a lot and might fall out. Staff AA also reported staff had to guide and cue the resident due to not being able to see well.

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F 309	Continued From page 97 During an interview on 5-9-13 at 7:49 a.m. direct care staff E reported they thought nursing staff kept the resident in bed because someone told him/her the resident had a stroke so he/she could not maintain his/her position in the wheelchair. At this same time direct care staff AA reported he/she also thought the resident laid down after every meal was because of positioning in the wheelchair. Staff AA reported the resident would lean forward and fell in activities and nursing staff were asked to lay him down. When asked why the resident didn't have wheelchair pedals on direct care staff AA reported he/she wondered the same thing because the resident could not hold up the left foot and it dragged on the floor. During an interview on 5-9-13 at 7:54 a.m. direct care staff BB said the resident did not have foot pedals on the resident's wheelchair because he/she was blind and tried to get up all the time and would trip and fall on them. Staff BB looked at the nurse aides and said "I can put foot pedals on the chair but someone would have to be with him/her all the time, they could not leave him/her alone." During an interview on 5-9-13 at 1:57 p.m. Administrative nurse K reported the expectation was for staff to position the resident upright in wheelchair or other chairs with feet on the floor or on the foot pedals. Staff K reported that if a resident propelled themselves with their feet they did not have foot pedals on but if they used their arms to propel they should have pedals on the chair. Staff K confirmed the resident should have had foot pedals on when staff pushed him/her to meals or other areas of the facility.	F 309		

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F 309	Continued From page 98 The facility failed to provide proper seating and positioning for a resident with physical limitations.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: The facility had a total census of 50 residents with 21 sampled. Three residents were sampled for pressure ulcers and based on interview, record review and observation the facility failed to prevent the development of a pressure ulcer on resident #51. Findings included: - Review of the admission MDS dated 11-26-12 revealed resident #51 had a BIMS score of 00 indicating the resident was severely cognitively impaired. The resident had unclear speech, sometimes made self understood and sometimes understood others, required extensive assist of two staff for transfers, toilet use, and extensive assist of one staff for bed mobility, walk in room, dressing, eating, personal hygiene. The resident had taken an antipsychotic for 2 days of	F 314		

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the 7 days look back period. The MDS indicated the resident was not at risk for developing pressure ulcers.

Review of the quarterly MDS(minimum data set) dated 2-18-13 revealed the resident had a BIMS(brief interview for mental status) score of 00 indicating the resident was severely cognitively impaired. The resident required extensive assistance of two staff for transfers, toilet use, and one staff for bed mobility, locomotion, dressing, eating, and personal hygiene, took a diuretic for 7 days, an antibiotic for 5 days, and an antipsychotic for 2 days of the 7 day look back period. The MDS further indicated the resident was not at risk for pressure ulcers but did indicate the resident had developed an infection of the foot and used a pressure relieving device for the wheel chair.

No Care Area Assessment(CAA) dated 11-26-12 triggered for pressure ulcers.

Review of the care plan dated 12-18-12 directed staff to use a heel boot on the right foot for pressure relief.

Review of the discharge summary from a local hospital dated 11-23-12 revealed no wounds to right heel.

Review of the nursing assessment dated 11-25-12 revealed no skin issues to both heels.

Review of the weekly skin assessment dated 12-5-12 revealed the resident had a large blister to the right heel which staff monitored and no special equipment was used.

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Review of the Nurse's notes dated 12-14-12 at 9:15 a.m. indicated the resident was lying in the bed with staff dressing and changing a brief. The resident was not responsive verbally at that time but did open eyes earlier at 6:30 a.m. when spoken to. The resident did, however, show facial grimacing when staff manipulated the right foot. The note indicated the resident was a full assist with ADL's and did not attempt to assist staff with dressing. The nurse note indicated the resident did not support any of his/her own weight for transfer but did have facial grimacing and moaning. After being placed in the wheelchair the resident's eyes remained closed.

Review of the Nurse's notes dated 12-14-1:45 p.m. the resident was taken to the clinic for a follow up appointment with family present. The resident became less responsive at 12:40 p.m. that day by just mumbling with his/her eyes closed as well as requiring staff assistance with the noon meal and required two staff for transfer due to not supporting his/her own weight.

Review of the physician's orders dated 12-14-12 directed the staff to have strict pressure relief to right heel.

Review of the weekly skin assessment dated 12-28-12 revealed a large soft black spot on bottom of right heel and the use of a pressure relieving boot.

An observation on 5-7-13 at 11:21 a.m. of the resident seated in a recliner chair, awake and alert, with the foot rest in the up position and no pressure relieving devices visible, he/she was

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speaking to the staff but not making clear sentences, was also making attempts to sit up and get out of the recliner chair after the direct care staff told him/her it was time to get up. The staff placed a lift belt around the resident's waist, secured it with the snap buckles and attached a strap to the sit to stand lift. The staff were giving the resident simple instructions to pick up his/her feet and put them on the lift foot pedal as well as asking the resident to hold the side arms of the lift which the resident was not able to follow commands on the first instruction and it took a few times of repeating by the staff to get him/her to follow the instructions. The resident was then taken to the toilet to void. While sitting on the toilet the resident continuously reached and grabbed for different objects including the toilet paper roll, the wall grab bar, the emergency call light string. After voiding and having a bowel movement, the staff performed peri care and place a clean dry brief on the resident. The staff continued to dress the resident in slacks and calf length socks with non-skid booties on the feet. An observation of the resident's skin condition revealed intact skin in the buttocks and peri area and on the right heel a nickel sized thick yellow flaky scab with pink intact skin around the heel area.

An observation on 5-8-13 at 8:10 a.m. revealed three staff assisted the alert resident to walk in the hall using a supportive walker, a gait belt and the wheelchair behind. The resident walked at least 50 feet then started to slow down and stop. The staff then asked if he/she was ready to set down. At that time the resident sat in his/her own wheelchair with the pedals turned to the side and began to self propel the wheelchair in the hall

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F 314	Continued From page 102 way. In an interview on 5-7-13 at 11:40 a.m. direct staff E reported the resident had a fall in November and broke the left elbow, when he/she returned from the hospital, he/she had an arm sling which decreased mobility and was unable to assist with bearing weight, dressing and daily cares due to decreased cognitive function which was very different from his/her behavior before the accident. After the staff had the doctor adjust the resident's medications, he/she was able to do more now and can help with simple things, stand with some support for balance, make needs known most of the time. The staff reported the resident had a boot on the right foot after he/she came back to the facility but was unsure of how the foot sore happened. The staff was aware the resident was to keep pressure off the right heel by using the boot. In an interview on 5-9-13 at 8:27 a.m. direct care staff KK reported when the resident returned from the hospital in November 2012, he/she was not very active and would stare off in space a lot. Staff KK stated the resident just sat there without talking much or reacting to people around. Staff did report the resident developing a blister on the right heel but was unsure of how it got there and did remember the resident having to wear a black heel boot for a long time. In a interview on 5-9-13 at 8:36 a.m. direct care staff I reported the resident came to the facility and was somewhat independent, could feed himself/herself and assist with ADL's, however, after returning from the hospital in November 2012, the resident had become a total care	F 314		

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F 314	Continued From page 103 needing extensive assistance from two staff for all ADL's including eating. The staff recalled the resident developing a problem with the right foot and having to wear a black boot on it for a long time with it just recently being removed. The facility failed to prevent the development of an pressure area on a dependant resident's right heel due to the changes in the resident's condition after a fractured arm.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: The facility census totaled 50 residents with 21 included in the sample. Based on observation, interview, and record review, the facility failed to ensure that residents with urinary incontinence received the appropriate treatment and services to restore as much normal bladder function as possible for 2 of 3 residents sampled for urinary incontinence. (#5 and #40) Resident #5's urinary incontinence went from happening occasionally to occurring frequently. This change in represented a decline in urinary incontinence.	F 315		

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Findings included:

- Review of resident #5's physician's orders, signed on 5/6/13, identified the resident with the following diagnoses: irritable bowel syndrome (a disorder that leads to abdominal pain and cramping and changes in bowel movements), stress incontinence (involuntary urination due to pressure on abdomen), and constipation.

Review of the Admission MDS (Minimum Data Set-a required assessment) dated 12/19/12, identified the resident with a BIMS (Brief Interview for Mental Status) score of 15/15 (indicated little to no cognitive impairment), required limited assist from staff with bed mobility, transfers, and toileting, and with occasional urinary incontinence (less than 7 episodes per week).

Review of the resident's significant change MDS (Minimum Data Set-a required assessment) dated 3/18/13, identified the resident with a BIMS (Brief Interview for Mental Status) score of 12/15 (indicated moderately impaired cognition), required extensive assistance from one staff with bed mobility, transfers, toileting, and frequently incontinent of urine. (More than 7 episodes of urinary incontinence pre week).

Review of the Urinary Incontinence and Indwelling Catheter CAA (Care Area Assessment-a further assessment) dated 3/21/13 revealed the resident required limited to extensive assistance from staff with toileting. It identified the resident experienced some dribbling of urine and wore incontinent products, had staff assist him/her at times with perineal care and changing

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of incontinence products. The CAA also noted the resident had a history of two surgeries on his/her bladder and had recently seen the physician where the resident described he/she would stand up and urine would flow right out. The CAA did not identify the reason for the decline in the resident's urinary incontinence.

Review of the care plan, dated 1/2/13, identified the resident had stress incontinence, wore incontinent briefs and had a long history of problems with incontinence, as the resident had two surgeries on his/her bladder. The care plan identified the resident had seen a urologist (physician that specializes in the urinary tract system) for his/her incontinence, and on 12/12/12 the urologist ordered new medications to try and see if it helped with the incontinence. The resident required help to change the incontinence products, and needed staff assistance with perineal care. The care plan identified the resident called frequently to use the toilet during the night. On 2/15/13, staff revised the care plan and directed staff to offer to help the resident to the toilet every 2 hours. The care plan lacked any further revisions to address if the new intervention assisted the resident with the increased urinary incontinence.

Review of the undated pocket sheets, used as a shortened care plan or "cheat sheets" for the direct care staff to carry with them revealed it identified the resident as "occasionally" incontinent and directed the staff to toilet the resident every 2 hours with the assistance of one staff.

Review of the resident's medical record revealed

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the facility had failed to conduct a further assessment of the resident's personal toileting habits, such as a 3-day toileting diary, to see if offering the resident assistance to the toilet every 2 hours was appropriate.

On 5/7/13 at 3:10 p.m., observation of Direct care staff F and OO revealed the staff assisted the resident to the bathroom. Staff F and OO used a mechanical lift and removed the resident's incontinent brief. Observation of the brief revealed it was wet. Staff F and OO provided perineal care, then placed a clean brief on the resident, then propelled the resident still in the mechanical lift, out of the bathroom to the bed and assisted the resident to lie down before the evening meal. Staff F and OO were very polite with the resident.

On 5/9/13 at 8:30 a.m., observation revealed Direct care staff I. Staff I stated that he/she had just helped the resident to the toilet with the sit to stand lift. The resident had been incontinent of bladder and Staff I had provided perineal care to the resident.

On 5/7/13 at 3:18 p.m., Direct care staff F identified the resident had been incontinent when taken to the bathroom and the resident needed help with perineal care. Staff F identified the resident had incontinent episodes, but Staff F did not know how frequently the resident was incontinent.

On 5/8/13 at 6:25 p.m., Direct care staff M stated the resident was incontinent at times, but still recognized the need to use the toilet and so would ring for staff to help. Staff M stated he/she

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helped the resident to the toilet before and after meals, when the resident went to bed, and whenever the resident rang and said he/she had to go.

On 5/9/13 at 8:35 a.m., Direct care staff I stated the resident did experienced some urinary incontinence, but it wasn't all the time. Staff I said that the resident would ring to go to the bathroom, so Staff I took the resident whenever he/she rang.

On 5/9/13 at 12:51 p.m., Licensed Nursing staff C said the resident's leg strength had started to decline when the resident moved to the facility, and since then the resident now used a wheelchair for mobility and staff used a lift to help with transfers. When asked why the resident now experienced more urinary incontinence than when the resident moved into the facility, Nurse C said it was because the resident went independently to the toilet and now he/she needs staff assistance, so he/she just sits in the wheelchair and wets.

On 5/9/13 at 2:51 p.m. Administrative Nurse K shared that the facility had identified in their QAPI (Quality Assurance and Performance Improvement) program that they needed to do a better job at developing toileting plans. Nurse K said that they were going to start doing the indepth assessments like 3 day voiding patterns later this month. As for resident #5 in particular, Nurse K stated that the resident had developed a UTI (Urinary Tract Infection) last month and they identified that and got the resident started on an antibiotic, then the resident developed shingles, so Nurse K really felt like that once they get the resident healthy, the incontinence will get better.

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Agreed that the staff should be clear on what is expected on the resident's toileting program and the staff should all be doing the same thing.

Review of the facility's undated policy for Care of the Incontinent Resident revealed it lacked direction to staff on how to develop a toileting plan for the incontinent resident.

Review of the facility's Care Plan Policy, dated 8/11, revealed the care plans are reviewed and revised within 92 days by the MDS Coordinator, and that the Care Plan may be reviewed and revised as needed at any time. It lacked guidance on the process for identification of the resident's changes in needs in between the quarterly MDS reviews, or to whom to report those changes to.

The facility failed to assess the changes in a resident's urinary incontinence status to develop an effective plan to maintain as much normal bladder function as possible. The resident went from experiencing urinary incontinence occasionally to frequently experiencing urinary incontinence.

- Review of the physician's review of orders, signed on 5/1/13, revealed resident #40 had the following diagnoses: hemiplegia (paralysis on one side of the body), joint contracture (chronic loss of joint movement due to structural changes in non-bony tissue) of the left upper arm, forearm, and hand, and dementia (a progressive disease of marked cognitive loss).

Review of the resident's annual MDS (Minimum Data Set-a required assessment) dated 4/29/13,

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identified the resident with a BIMS (Brief Interview for Mental Status) score of 2/15 (indicated severely impaired cognition), required extensive assistance of 2 staff for bed mobility, transfers, toileting, was frequently incontinent of bowel and bladder, and received no toileting program nor had staff attempted a bladder retraining trial.

Review of the Urinary Incontinence CAA (Care Area Assessment-a further assessment) dated 5/1/13, identified the resident had depression with resistance of care. The CAA identified the resident required extensive assistance in all ADL's (Activities of Daily Living), had a history of a stroke, which in turn had caused the resident to have long term hemiplegia to left side. The CAA identified the resident wore incontinent products and staff changed the products as needed, and the staff anticipated the resident's need for toileting due to the resident's cognitive status.

Review of the care plan, dated 5/2/13, revealed the resident required extensive assistance with his/her ADLs, had contractures of his/her left side and the resident could not move his/her left extremities much on his/her own. The care plan also identified the resident as incontinent of bowel and bladder and needed staff to help the resident to the toilet when the resident awoke, before and after all meals, and then before the resident went to bed. It also identified the resident needed to be checked and changed on bed checks at night. The care plan directed staff to apply barrier cream to the resident as needed. Lastly, the care plan directed staff to not place incontinent pads in the wheelchair on the cushion.

Review of the undated pocket sheets, used as a

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shortened care plan or "cheat sheets" for the direct care staff to carry with them revealed it identified the resident as incontinent and directed staff to toilet the resident every 2 hours with 2 staff assist. The guidance for staff on when to toilet the resident were different between the care plan located in the resident's record and the pocket sheets the direct care staff used.

Review of the resident's medical record revealed it lacked a further assessment of the resident's toileting habits, such as a 3-day voiding diary, to assist in the development of an individualized toileting plan for the resident.

On 5/7/13 at 11:57 a.m., observation revealed Direct care staff E and LL entered the resident's room, transferred the resident out of the recliner and into a wheelchair. The aides failed to check the resident's brief for urinary incontinence. Once the aides had the resident situated properly in the wheelchair with a foot rest for the left leg, Staff LL immediately assisted the resident to the dining room.

On 5/7/13 at 1:17 p.m., observation of the resident in his/her room after lunch revealed Direct care staff E and LL transferred the resident from the wheelchair into a standing position. Staff E held the resident upright while staff LL lowered the resident's pants, removed the wet incontinent brief, used wipes to provide perineal, applied a clean brief, then together the aides awkwardly lowered the resident into a recliner in the room. The staff did not attempt to toilet the resident.

On 5/8/13 at 4:24 p.m., observation revealed

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Direct care staff PP and Licensed nursing staff O entered the resident's room, and told the resident they planned to stand the resident up and check the resident's brief. Together the two staff attempted to apply a transfer belt to the resident's waist. While the two staff attempted to apply the transfer belt, a third staff, Direct care staff QQ entered the room at 4:28 p.m. to see if he/she could help. Staff PP and Nurse O decided to use a gait belt for transfer, applied the belt, stood the resident and transferred him/her into the wheelchair. Staff QQ asked if the staff had planned to check the resident's brief? Staff PP answered "yes" and propelled the resident to the toilet. Staff QQ told staff PP that the resident did not do so well in the bathroom, but that was ok, they would transfer him/her to the toilet. Together staff PP and QQ transferred the resident from the wheelchair onto the toilet with a gait belt and after removing the resident's wet incontinent brief. After allowing the resident time on the toilet, the staff then assisted the resident to stand. Staff QQ held the resident upright while staff PP provided perineal care. After staff PP provided perineal care and applied a clean brief, staff QQ transferred the resident onto the wheelchair.

On 5/8/13 at 6:43 p.m., observation revealed Direct care staff F and OO assisted the resident to his/her room, transferred the resident out of the wheelchair and into the recliner. The staff did not check the resident's incontinent brief or offer to assist the resident to the toilet.

On 5/7/13 at 12:03 p.m., Direct care staff E stated that the resident was incontinent of both bowel and bladder and did not have any way of knowing when he/she needed to go. Staff E identified the

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plan was for staff to check the resident's incontinent brief before and after meals, at bedtime and during the night and then changed it when needed.

On 5/8/13 at 6:25 p.m., Direct care staff M stated that he/she thought the resident was incontinent and staff were to check him/her routinely--staff M thought it was every 2 hours but he/she would have to check the care plan to be sure.

On 5/9/13 at 8:22 a.m. Direct care staff B stated the resident was on a check and change schedule. The staff used the facility's "standard times" to check the resident--before and after meals, at bedtime and during the night.

On 5/9/13 at 8:35 a.m., Direct care staff I identified that staff checked the resident's brief to see if it needed changed before and after meals, and at bed time. Staff I said the resident did not do so well on the toilet and staff just checked the brief for incontinence.

On 5/8/13 at 6:47 p.m., Licensed nursing staff O identified the resident was incontinent and that staff were to change him/her before and after meals, at bedtime, plus during the night.

On 5/9/13 at 1:45 p.m. Licensed nursing staff J described the resident as dependent on staff for toileting needs and incontinent of bladder. Nurse J stated staff were to check and change the resident before and after meals, at bedtime and throughout the night.

On 5/9/13 at 2:12 p.m. Licensed nursing staff C identified staff were to toilet toilet the resident

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every 2 hours, but especially before and after meals and at bed time.

On 5/9/13 at 2:51 p.m. Administrative Nurse K shared that the facility had identified in their QAPI (Quality Assurance and Performance Improvement) program that they needed to do a better job at developing toileting plans. Nurse K said that they were going to start doing the indepth assessments like 3 day voiding patterns later this month. Nurse K agreed that the staff should be clear on what is expected on the resident's toileting program and the staff should all be doing the same thing.

Review of the facility's undated policy for Care of the Incontinent Resident revealed it lacked direction to staff on how to develop a toileting plan for the incontinent resident.

Review of the facility's undated policy for Bowel and Bladder Incontinence Assessment revealed the MDS Coordinator will complete section H of MDS 3.0, Bowel and Bladder Assessment Form, Part A&B and document summary of findings in notes. Based on findings if retraining appropriate, proceed to training (See Bladder Training Policy and Procedure). If incontinence was triggered by the MDS 3.0, the Bladder Diary is done by the licensed Nurse in cooperation with CNAs and CMAs for three days to determine retraining potential.

Review of the facility's Care Plan Policy, dated 8/11, revealed the care plans are reviewed and revised within 92 days by the MDS Coordinator, and that the Care Plan may be reviewed and revised as needed at any time.

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F 315	Continued From page 114 The facility failed to assess an incontinent resident's individualized toileting habits to develop an effective toileting plan, and the staff failed to consistently follow the developed plan to help maintain as much normal bladder function as possible.	F 315		
F 320 SS=G	483.25(f)(2) NO BEHAVIOR DIFFICULTIES UNLESS UNAVOIDABLE Based on the comprehensive assessment of a resident, the facility must ensure that a resident whose assessment did not reveal a mental or psychosocial adjustment difficulty does not display a pattern of decreased social interaction and/or increased withdrawn, angry, or depressive behaviors, unless the resident's clinical condition demonstrates that such a pattern is unavoidable. This REQUIREMENT is not met as evidenced by: The facility had a total census of 50 residents with 21 sampled. Based on interview, record review and observations, the facility failed to provide services to ensure a resident who was initially assessed as not having psychosocial adjustment difficulty did not develop symptoms for 1 of 4 residents sampled for weight loss. (#16) Resident #16 developed weight loss after a fiend in the facility died. Findings included: - Review of resident #16's annual MDS (minimum data set) dated 3-4-13 revealed a BIMS (brief interview for mental status) score of 3 indicating the resident had severe cognitive	F 320		

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impairment, had no behaviors, did not have signs of depression, had clear speech, and was able to understand others and be understood. The resident required extensive assist of one staff with personal hygiene, dressing, eating, had no weight loss, no swallowing problems, took an antipsychotic for 3 days and an antidepressant for all 7 days of the 7 day look back period. The MDS revealed the resident's weight was 140 pounds.

Review of the cognitive loss CAA (care area assessment) dated 3-5-13 revealed the resident had dementia with behavioral disturbances/paranoia. The resident had depressed moods that were noted by the physician and were treated with Zoloft (an antidepressant) for refusal of care and decreased appetite. The CAA identified the resident's Zoloft was discontinued, but weight loss and increased depressed behaviors increased, so the Zoloft was restarted. The resident took Zoloft daily for depression, Depakote (mood stabilizer) for dementia with behaviors, was withdrawn, ate slowly and very little most of the time even with cues. The resident needed staff assistance and encouragement, and showed resistance with meals, care, and medications. He/she had trouble with memory, was confused at times, did come out of room and sat next to a male/female resident in the facility but often sat with eyes closed, and required extensive assistance with ADL's (activities of daily living).

Review of the psychotropic drug use CAA dated 3-5-13 revealed the resident had dementia with behavioral disturbances/paranoia, needed Zoloft daily for depression and was withdrawn the

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majority of the time.

Review of the care plan for general information dated 8-9-2011 and revised on 3-6-13, revealed the resident enjoyed attending events with a fellow male/female resident and friend. The care plan directed staff to sit them together for events such as music and watching television in the lobby. The care plan identified the resident at times would hit, kick, scratch or spit at staff if they tried to care for the resident and he/she did not want them to. On 3/22/13, the resident's friend passed away. On 3-25-13, the physician discontinued the resident's Zoloft--given for the resident's depressive moods and withdrawn behavior. On 3-29-13, staff discontinued the intervention for staff to have the resident sit with the friend.

Review of the care plan for meals/snacks dated 8-9-2011 and last reviewed on 3-6-13 indicated the resident needed cues to eat and was fed by staff depending on mood, was given a shake (supplement) with all meals for increased intake.

Review of the facility's weekly weight report revealed the resident's weight on May 6, 2013 was 110 pounds.

According to the facility's weight report, the resident lost a total of 30 pounds between 3-4-13 and 5-6-13, over a 63-day period. The weight loss percentage totaled 21.4%, a significant amount.

Review of the meal intake logs for the month of March 2013 revealed a meal intake average of 37% with 6 meals refused.

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Review of the meal intake logs for the month of April 2013 revealed a meal intake average of 35% with 27 meals refused.

The facility had not calculated a meal intake average for the month of May, but Dietary staff D confirmed on 5-9/13 at 12:07 p.m. that the resident had refused most of the meals for the month of May.

Review of the behavior symptoms monitoring from February 2013 through April 2013 revealed the resident refused care for personal hygiene on 2-1-13, and 3-30-13 as well as refused care with personal hygiene, eating, medicine and dressing on 3-5-13.

Review of activities assessment completed on 2-13-13 in comparison to the assessment completed on 12-12-12, revealed the resident had declined in the participation in activities, rarely initiated conversation, did not enjoy small groups, and did not prefer to be out of his/her room. The assessment lacked identification of the resident's decline.

Review of the social service notes dated 3-11-13 revealed a visit with the resident who smiled and gave 1 to 2 word answers with no concerns voiced at that time.

Review of the social service notes dated 3-12-13 revealed the facility had a care plan meeting and would continue the same plan of care. The notes further indicated that social service provided 1 to 1 visits for social and mental stimulation, during the visits the resident had talked about daily

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seasonal events, family personal needs and social services would continue to visit and keep in touch with family. The social services failed to identify any further psychosocial changes for this resident. The clinical record lacked further evidence of social service involvement when the resident's mood declined. The social service notes lacked any monitoring of the resident's depressive moods after 3-25-13 when the physician discontinued the resident's antidepressant, Zoloft, even though the resident had a history of a previously failed attempt at a discontinuation of the medication.

Review of the nurse's notes dated 3-20-13 at 9:45 a.m. revealed staff reported the resident was not swallowing food and drink but was holding it in his/her mouth which had progressively worsened during the week. The note indicated the resident was no more confused than normal. Staff placed a call to the physician to discuss a swallowing evaluation. At 10:30 a.m. the staff had spoken with the physician who gave orders to taper Depakote (mood stabilizer) and Zoloft (antidepressant), and did not order a swallow evaluation.

Review of the nurse's note dated 3-28-13 at 4:15 p.m. revealed the resident ate very little lunch, spoke very little, and made little eye contact. The notes revealed a "special friend " had passed away approximately a week ago.

Review of the dietician notes dated 4-2-13 revealed the resident's intake and weight had been decreased since mid March. The notes further indicated the resident had been reluctant to open his/her mouth and at some meals refused

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any intake at all.

Review of the nurse's notes dated 4-2-13 at 2:30 p.m. revealed the resident had a significant weight loss over the last month along with tremendous decrease in appetite and refused to eat and drink most times.

Review of the nurse's notes dated 4-3-13 revealed the resident ate very little, was becoming very antisocial, did not smile and stared aimlessly as well as averted eye contact.

Review of the dietician notes dated 4-16-13 revealed the resident was put on "comfort care" by the physician. The notes revealed the medication changes made on 3-20-13 could have an effect on intake and a dentist appointment was set for May 8, 2013 to check oral status.(8 weeks after identifying the resident was having difficulty chewing and swallowing food) The notes further indicated the resident was started on warm fluids and the foods were to be at either room temperature or lightly warmed (to prevent pain to teeth for extreme temperatures), and provided hot cereal at all meals with pudding and a pureed texture on all hot meals.

Review of the dietician notes dated 4-23-13 revealed the resident continued on pureed food and continued to have very little intake. The notes indicated the resident shook his/her head "no" when offered food. The notes further indicated that most of the time and when he/she took a bite of food or drink it ran back out of his/her mouth. The notes indicated it appeared to the staff as if the resident just wanted to be left alone.

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Review of the nurse's notes on 4-25-13 revealed the resident was admitted to a local hospital for acute renal (kidney) failure.

The resident re-admitted to the facility on 4-27-13 from the hospital.

Review of the nurse's notes on 5-9-2013 at 5:20 a.m. revealed the resident passed away.

An observation on 5-7-13 at 11:52 a.m. revealed the resident sat at a table in the dining room, his/her head was hanging downward. The resident was served pureed chicken with gravy, mashed potatoes with cheese, and pureed spinach, a 6 ounce glass of orange juice and 8 ounce glass of water. At 11:56 after attempts from dietary staff to assist the resident with the meal, and the resident would shake his/her head "no" and refused the food and drink, the resident then was removed from the dining area and taken to his/her room and assisted to bed.

On 5-7-13 at 12:16 p.m. in an interview direct care staff I reported the resident had not been eating for at least 2 weeks and he/she refused meals and liquids. Staff reported he/she had another resident friend who passed away recently and the resident had declined since then. Direct care staff I identified the resident's "friend" had passed away at the end of February 2013 or beginning of March 2013. Staff I stated "The resident and the friend were very close and if asked they would say they were married to each other." "The resident's friend used to come looking for him/her all the time stating "where's my (resident's name)?" They sat together at the dining table for meals and during activities. The

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resident would smile when the friend was around. Staff stated "They even took their picture together." Staff pointed to a framed photo of the resident and the friend sitting close together, they both had smiles. Staff I reported the resident would feed himself/herself some of the time when the friend was present at the meal, however, after the friend passed away, there was a noticeable decline in the resident from that time.

On 5-9-13 at 11:28 a.m. in an interview Social Service staff A reported the resident had declined over the last three months, slept for increasing periods of time, and was close to another resident who passed away recently, however, staff A then indicated that due to having dementia the resident would not have remembered the other resident who passed and felt the resident was no more depressed than previously. Staff A reported it was his/her opinion the resident was not depressed due to the other resident passing away. Staff A reported he/she does regularly attend the Quality Assurance meetings and did attend in March 2013 and was made aware of the change in the resident's status as far as refusing meals and the weight loss. Staff A reported not having attended the Quality Assurance meeting in April 2013 due to other appointments, however, did review the meeting notes and was aware the resident continued to have difficulty with refusing meals and weight loss. Staff A verified there were no further evaluations for depression performed on this resident and also verified that between the dates of 3-11-13 and 4-29-13 there were no documented 1 to 1 visits with this resident.

On 5-9-13 at 12:07 p.m. in an interview dietary staff D reported the resident had another resident

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friend who encouraged him/her to eat and sat with him/her at meals and activities. The resident's friend passed away recently. The resident began refusing meals and supplements around that same time. Staff D further indicated this was brought up in the Quality Assurance meetings on 3-12-13, and each week thereafter. Staff D reported attempts were made in an effort to improve meal intake including a change of location of the dining to be away from other people, room temperature foods and drinks were offered, other staff encouragement, all with no better results. Staff D confirmed there were no swallow evaluations performed, no discussion for reviewed discontinued medications, discussions towards new medications to improve appetite with no follow through and no changes were made to the resident's care plan.

On 5-9-13 at 2:33 p.m. in an interview Administrative nursing staff K reported the resident's weight loss and refusal of the meals had been brought up at the Quality Assurance meetings. Other staff had reported the resident had been close to another resident friend who resided at the facility evidenced by them sitting together at meals and for activities and the other resident had recently passed away.

On 5-17-13 at 11:00 a.m., Administrative nursing staff K stated that the facility's process for identifying weight loss was done when Dietary staff D entered the weights into a computer program and received a weight report. This weight report was then utilized at a weekly care plan meeting where several Administrative staff, Consultant NN, and Social Service staff A gather to discuss what interventions had been

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attempted, which ones did not work, and what else needed to be tried. When asked which staff monitored for an increase in depression symptoms, Nurse K confirmed that it was Administrative Nursing staff R, when he/she completed the MDS. When Nurse R identified an increase in depression, Nurse R then shared that information with Social Service staff A and the resident's physician.

Review of the facility's Mental and Psychosocial policy, dated 8/2011, revealed the following:
1. Upon admission an assessment is completed on residents and the nursing staff addresses "mental status". The MDS Coordinator and Social Services during admission review mental/psychosocial needs. They also review resident's mental/psychosocial needs quarterly and upon any significant change. The interdisciplinary team also acknowledges any changes in resident's mental/psychosocial needs together as a team and the nursing home staff will implement care in collaboration with other members of the interdisciplinary team - ranging from the physician (who may need to consider medical issues that are complicit in care needs) to the nursing assistant (who provides the majority of care) - as well as the resident and his/her family members.

2. If it is determined that a resident is depressed, either by staff reporting to charge nurse or th interdisciplinary team, notification will be sent to the physician, one on one visits will be conducted to help identify other measures that might help depression prior to medication changes or additions, and if needed, will ask for psychiatric consult and treat.

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F 320	Continued From page 124 3. Social Services will follow up to help address all on-going psychosocial needs. 4. For those residents who have an assessment that does not reveal a mental or psychosocial adjustment difficulty, display a pattern of decreased social adjustment difficulty, display a pattern of decreased social interaction and/or, display increased withdrawn, angry, or depressive behaviors staff will monitor in between assessments using the care tracker tool. The facility failed to assess the cause for recent changes in psychosocial adjustment and provide services and or treatments to prevent decline of the mental and physical health and well-being of resident #16 when he/she had weight loss, refused meals, activities and medications after his/her friend in the facility passed away.	F 320		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility census totaled 51 residents with 21 residents included in the sample. The sample included 3 residents reviewed for accidents. Based on observation, record review, and	F 323		

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interview, the facility failed to ensure 2 of the 3 residents remained free of accidents related to the failure to consistently utilize planned fall prevention interventions. (#59 and #5)

Findings Included:

- Review of resident #59's signed physician order sheet dated 4-11-13 included the following diagnoses: Bilateral Subdural hematoma (a collection of blood below the inner layer of the dura but external to the brain and arachnoid membrane), Dementia (progressive mental disorder characterized by failing memory, confusion) with behaviors/ agitation, and insomnia (inability to sleep). Review of the face sheet revealed an admission date of 4-12-13.

Review of the admission MDS (Minimum Data Set 3.0, a required assessment) dated 4-22-13 revealed a BIMS (Brief Interview for Mental Status) score of 2 that indicated severe cognitive impairment. It also revealed the resident had difficulty focusing, was easily distracted and had disorganized thinking that fluctuated throughout the day. The MDS also revealed the resident had physical and verbal behaviors toward others, and behaviors not directed at others (scratching self, screaming out, inappropriate gestures, or sexual acts, disruptive sounds) 1-3 days out of past 7. It also revealed the resident had a fall in the past 6 months prior to admission to the facility and had 2 falls since admission. It revealed the resident required extensive assistance of 1 for all cares except for walking in room which required limited assistance and used a wheelchair for mobility. The MDS also revealed the resident was not steady but able to stabilize without staff

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assistance with transfers, turning around, or moving on and off the toilet. It also revealed the resident had moderately impaired vision and could not read the newspaper headlines, but could identify objects.

Review of the Visual Function CAA (Care Area Assessment) dated 4-23-13 revealed the resident had macular degeneration and considered to be blind. Staff pushed the resident in the wheelchair in the halls and provided extensive assistance with eating and dressing. The resident did not wear his/her glasses because they did not help so they were left at home.

Review of the Psychosocial Well-Being CAA dated 4-23-13 revealed the resident resisted assistance with care and reported being depressed. The resident received Remeron for depression, Nortriptyline for insomnia and behaviors, and Ativan as needed for increased anxiety.

Review of the Fall CAA dated 4-24-13 revealed the resident was unsteady when he/she stood up and had fallen at home prior to admission. The resident received Remeron routinely for depression, Nortriptyline for insomnia and behaviors, and had Ativan for increased anxiety as needed. The resident frequently wanted to get up and use the toilet and had occasional urinary incontinence. It revealed on 4-12-13 the resident had gotten up from wheelchair and fell to knees, and again on 4-13-13 fell from wheelchair to his/her knees. It revealed the resident had a bed/chair pad alarm to be under him/her to notify staff if resident stood because of frequently attempting to stand without assistance.

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F 323	Continued From page 127 Review of the Fall Risk Assessment dated 4-24-13 the resident had a score of 22 which indicated high risk for falls with an intervention marked for bed/chair pad alarm. Review of the care plan updated on 5-5-13 revealed a problem regarding fall risk initiated on 4-24-13 included the following interventions and updates: 4-13-13 - falls from 4/12,13/13 intervention for bed/chair alarm 4-29-13 - toilet the resident mid-morning 5-2-13 -- intervention for a tab alarm to be on 5-3-13 -- intervention for baby monitor placed in hallway 5-3-13 -- intervention for anti-roll back brakes to be added to the wheelchair 5-5-13 -- intervention to change the bed to a low bed and place a pad on the floor beside the bed The care plan also had a problem regarding ADLs (Activities of Daily Living) dated 4-24-13 which indicated the resident could stand independently, was unsteady, and needed extensive assistance of staff with transfers and bed mobility. It directed staff to use a wheelchair throughout the day because the resident constantly wanted to be on the move. It also revealed the resident felt like he/she needed to use the bathroom about every thirty minutes and staff to monitor for signs of needing to toilet. The care plan also included a concern regarding mood and behaviors regarding the resident had trouble with impulse control and frequently got up unassisted. It directed staff to walk or push the resident in the wheelchair in the facility to help calm the resident as able.	F 323		

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Review of the nurse's notes revealed the resident had 10 falls since admission on 4-12-13, including a fall on 5-5-13 at 11:15 a.m. when staff found the resident on the floor next to the bed lying on his/her stomach.

Review of the fall investigation report for the fall on 5-5-13 at 11:15 a.m. revealed an intervention to put a baby monitor in the resident's room to help with monitoring the resident.

An observation on 5-7-13 at 11:37 a.m. revealed the resident laid in bed on his/her back with right knee raised pointed toward the ceiling. The resident had a foam mat on the floor, a pressure pad alarm on the bed, and a personal tab alarm connected to his/her shirt. There was also a baby monitor that sat on the heater/air conditioner unit that was not plugged in.

An observation on 5-7-13 at 2:35 p.m. revealed the resident laid in bed facing the wall with a pad alarm under the resident, tab alarm on, pad on the floor beside of the bed, bed in the lowest position, and the baby monitor remained unplugged that sat on the heater unit.

Observation on 5-8-13 at 3:14 p.m. revealed maintenance staff CC worked in the resident's room lowering the back of the resident's wheelchair seat. The resident lay in bed with a tab and pressure pad alarm on, pad on the floor, and bed in lowest position. The baby monitor on the heater remained unplugged.

During an interview on 5-7-13 at 1:12 p.m. direct care staff AA reported to prevent falls staff

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switched out the bed to a lower bed, had a mat on his/her floor beside the bed, and staff had to watch the resident when in the wheelchair because he/she would lean a lot and might fall out of the wheelchair.

During an interview on 5-8-13 at 3:23 p.m. direct care staff W reported that staff kept an eye on the resident, checked more frequently, made sure the bed was in the low position, and watched for signs of agitation. He/she also reported to make sure the resident had the mat on the floor and he/she had a tab and bed alarm on. When asked if the resident had a pad alarm on in bed and a tab alarm and the same in the wheelchair, staff W commented that he/she thought that once staff put the resident in bed he/she just had the pad alarm on, but it just depended on who took care of the resident. Staff W then went to the resident room and confirmed the monitor that was on the heater was a baby monitor and it was unplugged.

During an interview on 5-9-13 at 12:51 p.m. licensed nurse C reported that specific things that staff were to do for the resident to prevent falls included the baby monitor in the room but it started beeping today so the facility needed to get another one. When it comes to supervising staff and making sure things are being done, staff C stated it was really hard. Sometimes the nurse just has to look from side to side and look into the rooms to see that things are in place and asking the staff if they did what they were supposed to.

During an interview on 5-9-13 at 1:57 p.m. Administrative nursing staff A confirmed the resident should have had the baby monitor on.

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Review of the Fall Tracking Program revised on 8/11, revealed "The Charge Nurse on duty at the time of the fall will determine a new/different intervention to prevent further falls. This intervention will be posted on the care plan in the chart and in the room if appropriate. All staff will help with implementation of POC (Plan of Care) to prevent further falls."

The facility failed to consistently utilize planned fall prevention interventions that included the use of the baby monitor in the room on the care plan.

- Review of resident #5's physician's orders, signed on 5/6/13, identified the resident with the following diagnoses: irritable bowel syndrome (a disorder that leads to abdominal pain and cramping and changes in bowel movements), stress incontinence (involuntary urination due to pressure on abdomen), and constipation.

Review of the Admission MDS (Minimum Data Set-a required assessment) dated 12/19/12, identified the resident with a BIMS (Brief Interview for Mental Status) score of 15/15 (indicated little to no cognitive impairment), required limited assist with bed mobility, transfers, and had falls in the 2 months prior to the admission to the facility.

Review of the resident's Significant change MDS (Minimum Data Set-a required assessment) dated 3/18/13, identified the resident with a BIMS (Brief Interview for Mental Status) score of 12/15 (indicated moderately impaired cognition), required the extensive assistance of one staff for bed mobility, transfers, was unsteady and only able to stabilize with staff assistance when moving from seated to standing positions,

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walking, turning around, moving on/off toilet, and surface to surface transfers. The assessment also identified the resident had falls since admitting to the facility, 2 without injury and 2 with injury.

Review of the Fall CAA (Care Area Assessment-a further assessment) dated 3/21/13 revealed the resident had frequent falls when he/she lived at home with his/her spouse. The CAA identified the resident had fallen frequently since admission to the facility because the resident was not compliant with calling for assistance. The CAA identified that staff had not determined the reason for not calling yet as forgetfulness or the resident just chose not to call for assistance from staff. It identified the resident had a decrease in physical abilities and still tried to do things independently without calling for help. The CAA identified and described the resident's 8 falls, 4 of which occurred with urinary incontinence or in/on the way to the bathroom, and 3 of which happened when the resident attempted to get out of bed independently. The CAA identified the resident took 10 mg (milligrams) of Valium (an antianxiety) medication every evening for neuropathy (disease of the peripheral nerves). The CAA also identified the resident had an unsteady gait with a "sway" when the resident walked. Lastly, the CAA identified the resident at very high risk for falls and at that time the resident had alarms to notify staff when the resident got up unattended. The CAA identified the resident continued to get up unattended. The CAA identified staff developed interventions to try to prevent the resident from falling.

Review of the care plan, dated 1/2/13, revealed

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that staff noted the resident had gotten up on his/her own without calling for help. The resident required reminding to call for help due to a history of many falls in the month prior to the admission to the nursing facility. The resident could get upset when told by staff to not ambulate independently because he/she remembered ambulating independently when he/she lived in his/her own home.

On 3/22/13, staff added the following information: "(The resident) (takes) Valium (an antianxiety) at night for treatment of his/her neuropathy.
On 3/30/13, staff added "fall at sink standing unassisted to reach tooth paste. Staff to put toothpaste (and) tooth brush beside sink when assisting ready for evening meal within reach."
On 2/22/13, staff added: "Fall--chair pad alarm applied at all times."
2/23/13, staff added: "Fall--back up brakes checked for functioning."

Review of the undated pocket sheets, used as a shortened care plan or "cheat sheets" for the direct care staff to carry with them revealed it did not identify the resident as a fall risk, or identify what staff are to do to prevent falls.

Review of the nurse's notes revealed the resident had falls on the following dates: 1/4, 1/14, 1/19, 1/23, 2/1, 2/14, 2/23, 2/24, 3/20, 3/30, and twice on 4/13. Review of the fall investigations into the last 4 falls revealed staff documented the care plan had been reviewed and interventions developed, but the care plan did not identify any new interventions other than the one staff wrote regarding providing the toothbrush at the sink and within reach of the resident. The investigations

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also did not identify if the interventions in place were active/in place at the time of the falls, such as the chair pad alarm.

On 5/7/13 at 3:10 p.m., observation revealed Direct care staff F and OO assisted the resident to the bathroom then back to bed with the use of a mechanical lift. Observation revealed the staff did not place any type of pad alarm under the resident when the staff assisted the resident into bed.

On 5/7/13 at 12:03 p.m., Direct care staff E identified the resident has fallen at least once that he/she could remember and since then staff were to place a personal alarm on the resident all the time.

On 5/7/13 at 3:18 p.m., Direct care staff F stated the resident would try to get up without calling for staff help and also that he/she was to wear a pad alarm at all times.

On 5/8/13 at 6:25 p.m., Direct care staff M stated that the resident had falls, that the resident believed he/she could walk and so he/she tried to get up from the bed. Staff M stated that staff now put a pad alarm on the when he/she is in bed and in the wheelchair.

On 5/9/13 at 8:35 a.m., Direct care staff I stated the resident had falls, mainly on the evening shift or night shift. Staff I identified when the resident moved into the facility, the resident was able to stand and walk "some", but since then he/she had slowly lost that ability and he/she now used a wheelchair all the time and it was getting to the point that staff had to use a mechanical lift to help

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him/her to stand during transfer. Staff I further identified the resident did not remember that he/she could no longer stand independently, so he/she would try to stand up out of the bed. Staff I stated staff reminded the resident frequently that he/she now needed help to transfer, and also the resident had a pad alarm that staff used all the time.

On 5/9/13 at 12:51 p.m. Licensed nursing staff J stated the staff tried to remind the resident to call for help and that did not seem to work. Staff now use the alarm and that seemed to have helped because the resident had not had nearly the falls he/she used to. Nurse J could not remember the kind or type of alarm the resident used, or when it was to be on.

On 5/9/13 at 2:51 p.m. Administrative Nurse K stated that he/she understood the confusion about the pad alarm and he/she planned to make sure it was more clear in the care plan the type of alarm and when it was to be used for the resident. Nurse K did not know if the resident should be using a pad alarm while in bed, or just while the resident sat in the chair. Nurse K agreed that the fall investigations should identify the newly developed intervention, as well as the care plan. Nurse K also agreed that the investigation should address if staff had the previously developed interventions in place at the time of the fall to determine if they were effective.

Review of the facility's undated policy on Fall Tracking Program revealed the following:
"c. Resident's name will remain in the 3-day book until fall charting is completed. MDS Coordinator, one nurse and ADON (Assistant Director of

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F 323	Continued From page 135 Nurses)/DON (Director of Nurses) will evaluate whether resident fall risk level should change. The Charge Nurse on duty at the time of the fall will determine a new/different intervention to prevent further falls. This intervention will be posted on the care plan in the chart and in the room if appropriate. All staff will help with implementation of POC (Plan of Care) to prevent further falls." The facility failed to utilize the assistant device of a pad alarm at all times to a resident with frequent falls in an attempt to prevent further falls.	F 323		
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: The facility's census totaled 50 residents with 21 included in the sample. Based on observation, interview, and record review, the facility failed to provide sufficient fluids for a resident between meals to ensure proper hydration and health for 1 of 1 resident sampled for hydration. #40 Findings included: - Review of the physician's review of orders for resident #40, signed on 5/1/13, revealed the resident had the following diagnoses: Left-sided hemiplegia (paralysis on the left side), joint contracture (chronic loss of joint movement due to structural changes in non-bony tissue) of the	F 327		

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left upper arm, forearm, and hand, and dementia (progressive disease with marked cognitive loss).

Review of the resident's annual MDS (Minimum Data Set-a required assessment) dated 4/29/13, identified the resident with a BIMS (Brief Interview for Mental Status) score of 2/15 (indicated severely impaired cognition), required the extensive assistance from one staff with eating, experienced a weight gain of 5% or more in the last month or 10% or more in the last 6 months, and received a mechanical soft diet. The assessment also did not identify the resident with hydration issues.

Review of the Nutritional CAA (Care Area Assessment-a further assessment) dated 5/1/13, revealed the resident had a previous stroke which in return has caused the resident long term hemiplegia to the left side. It also identified staff assisted the resident to eat, but could independently eat bites and drinks but often does not get much accomplished because of the resident's short attention span. Staff served the resident a mechanical soft to aide in chewing and swallowing. Staff must transfer the resident into a regular dining room chair at meals because of the resident's wandering habits and short attention span. The staff must anticipate the resident's needs, and the resident had a significant weight gain in the last 30 days. The CAA also identified the resident usually left 25% or more of the meals uneaten.

Review of the care plan, dated 5/2/13, revealed directions to staff to transfer the resident into a dining room chair, to get the resident's silverware out and cut up the resident's food. It also

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identified the resident used a divided plate for eating. It also directed staff to serve the resident a mechanical soft or pureed diet, cue the resident to eat, but the resident frequently needed assistance with eating. The care plan also directed staff to encourage the resident to eat more at meals, offer the resident snacks when he/she was in the halls to supplement the dietary intake, that the resident had a lactose intolerance, took protein shots in juice and soy milk in the evening for extra supplementation. Lastly, the care plan identified the resident's food likes as fruit, hard cheese, raw carrots, hamburger, fish, orange sherbet, and tea. The resident's dislikes included chicken, eggs, cottage cheese, sour cream, or yogurt. The care plan did not identify any issues with hydration, other than the lactose intolerance.

Review of the undated pocket sheets, used as a shortened care plan or "cheat sheets" for the direct care staff to carry with them directed staff to transfer the resident to a regular chair while eating and to cue and assist the resident to eat. How the resident ate depended on how he/she was. It also identified the resident wore a clothing protector. It did not identify any issues with hydration.

Review of the residents nutrition assessment, dated 6/19/12, revealed the RD identified the resident required 2000 cc (cubic centimeters)/day to maintain hydration needs.

Review of a physician's progress note, dated 12/18/12 and timed 3:00 p.m. revealed an order for staff to "Push oral fluids" and to obtain some laboratory blood work.

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Review of a comprehensive metabolic panel (CMP- a type of blood test) obtained on 1/16/13 revealed the resident's BUN (Blood-Urea-Nitrogen--monitors function of kidneys and liver) was high at 39.0 mg/dL (milligrams per deciliter). The laboratory sheet identified normal test levels are 9.0 - 23.0 mg/dL.

Review of a comprehensive metabolic panel obtained on 1/24/13 revealed the resident's BUN totaled 37.0 mg/dL. The resident's BUN/Creat ratio (Blood-Urea-Nitrogen/Creatinine--in cases of dehydration, BUN may increase in a higher proportion than the creatinine) was 30.8, which was high. Normal levels are 6.0 - 22.0.

Review of the physician's review of orders, signed on 5/1/13, revealed the physician gave the order for staff to serve a liberalized Geriatric diet, texture as tolerated and for staff to push fluids.

Observation on 5/6/13 at 10:55 a.m. revealed the resident sat in a recliner in his/her room. When asked, the resident provided his/her tongue for observation. The resident's mouth had very little moisture, and the resident's tongue had furrows.

On 5/7/13 at 11:22 a.m., observation revealed the resident sat in a recliner in his/her room. The water pitcher in the room sat on a bedside table on the resident's left side--the side affected by the stroke.

On 5/7/13 at 11:57 a.m., 2 nurse aides, Direct care staff E and LL entered the resident's room and transferred the resident from the recliner into the wheelchair. Once the staff had positioned the

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resident into the wheelchair with a foot rest, staff LL propelled the resident to the dining room without offering a drink. Staff LL then transferred the resident into a regular chair in the dining room and left the resident. No glasses of fluid sat on the table for the resident to drink.

On 5/7/13 at 12:09 p.m., observation revealed staff served the resident an 8 oz (ounce) glass of grape juice, and an 8 oz glass of ice water with the meal. The staff handed the glass of juice to the resident and the resident drank all of the juice, so then staff offered the resident the ice water. The resident did not drink much of the ice water.

On 5/7/13 at 12:47 p.m., observation revealed the resident had not drank much of the ice water, so the staff went and got an 8 oz container of chocolate soy milk and placed it in a 12 oz glass. The staff came back with it and the resident immediately started drink it.

On 5/7/13 at 1:07 p.m., observation revealed the resident had drank all of the juice and the milk, but very little of the ice water, or 540 cc of fluid. Staff assisted the resident back to his/her room.

On 5/7/13 at 3:06 p.m., observation revealed a Direct care staff passed juice to the residents in their rooms. The staff gave the resident a small 90 cc cup of grape juice and left the resident with it as the resident sat in a recliner. Within 7 minutes, the resident had drank all of the juice. The Direct care staff did not stop by the resident's room to see if the resident had drank the juice or see/encourage the resident to have any more.

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On 5/8/13 at 9:00 a.m., observation revealed the resident sat in a regular chair in the dining room, eating breakfast. The staff had served the resident a mechanical soft meal in a divided plate with 8 oz of chocolate soy milk, an 8 oz glass of grape juice and an 8 oz glass of ice water. A nurse aide sat beside the resident assisting the resident to eat and drink. The resident drank all of the juice and milk, not much of the ice water. Staff did not offer any more juice or milk to the resident before the staff assisted the resident back to his/her room.

On 5/8/13 at 11:00 a.m., staff passed juice to the residents in the activity in the activity room. The resident sat in a recliner in his/her room and did not participate in the activity, so staff did not offer the resident any juice.

On 5/8/13 at 12:00 noon., observation revealed the staff served the resident the noon meal with 8 oz of juice and 8 oz glass of ice water.

On 5/8/13 at 12:26 p.m., observation revealed a nurse aide handed the resident a glass of juice and the resident drank it all. The aide then went and got 8 oz of chocolate soy milk and gave that to the resident to drink and the resident drank it all. The resident did not drink the ice water, but staff did not offer the resident any other fluids.

On 5/8/13 at 2:51 p.m., observation revealed a nurse aide passed snacks and juice to the residents in their rooms. The aide did not stop in the resident's room to offer a drink of juice to him.

On 5/8/13 at 4:24 p.m., observation revealed Direct care staff PP, QQ and Licensed nursing

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staff O assisted the resident to the toilet and then into a wheelchair prior to the evening meal. During the care, none of the staff offered or encouraged the resident a drink out of the resident's water pitcher.

On 5/7/13 at 12:03 p.m., Direct care staff E identified the resident ate and drank well. Staff E stated he/she was not aware of any special instructions on the resident's fluids, like if the physician had ordered a fluid restriction or if staff were to give the resident extra fluids.

On 5/9/13 at 8:22 a.m. Direct care staff B said the resident received a pureed diet, but regular fluids, and he/she was not aware of any fluid restrictions or need to encourage fluids for the resident. Staff B described encouraging fluids to residents meant making special trips into the room to offer fluids, or a drink out of their water pitchers in their rooms, like every 30 minutes or so.

On 5/9/13 at 8:35 a.m. Direct care staff I stated that the resident received a pureed diet and was not on any other type of special diet for fluids, including encouraging fluids, because the resident drank fluids well. Staff I stated that the resident received all his/her fluids at meals and when he/she went to activities. Staff I identified that fluids given in between meals were given out usually during activities. Staff I described encouraging fluids meant bringing extra juices to the resident between meals and it is usually for those that don't like to drink or it's hard to get them to drink.

On 5/8/13 at 6:45 p.m. Licensed nursing staff O stated the resident did not have any problems

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drinking, and lacked awareness of the resident requiring staff to encourage fluids. Nurse O did state he/she expected staff to offer fluids to the residents every time they were in the room.

5/9/13 at 1:45 p.m. Licensed nursing staff J identified the resident did not have trouble drinking fluids, and did not know if staff were to encourage fluids to the resident or not. The staff pass juices in activities, that is when they get between meal drinks.

On 5/9/13 at 2:08 p.m., Licensed nursing staff C stated the resident was not not on any kind of fluid restriction, and that staff gave the resident "lots" of fluids at meals. Nurse C stated that if he/she saw the resident with a dry mouth, then he/she would tell the staff to push fluids at meal times, but since the resident drinks well, staff don't really need to do that. Nurse C identified the staff give the resident drinks from the water pitcher whenever they are in the room with the resident as it is now, so Nurse C knew the resident received plenty of fluids.

On 5/9/13 at 2:51 p.m. Administrative Nurse K stated he/she expected the staff to give drinks out of the water pitchers when the aides are in the rooms working with the residents. Nurse K also identified that encouraging or pushing fluids meant staff were to bring extra fluids between meals to the residents and offer them more frequently throughout the day. Nurse K stated he/she was not aware that the doctor wanted the staff to push fluids for the resident.

Review of the facility's undated Hydration policy revealed the following guidance:

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F 327	Continued From page 143 2. Encourage fluids at all meals. 3. All staff encourage fluids in-between all meals. The facility failed to encourage fluids to a resident at risk for dehydration as ordered by the physician.	F 327		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: The facility reported a census of 50 residents,	F 329		

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with 10 residents sampled. Based on interview, observation, and record review the facility failed to ensure that 5 of 10 sampled residents were free from unnecessary medications. The facility failed to monitor medications, perform dose reductions, and medications without indications for use, for residents #5, #18, #40, #54, and #59.

Findings included:

- Review of resident #54's admission MDS (minimum data set) dated 2/19/13 revealed a BIMS (brief interview for mental status) with a score of 15 (cognitively intact). Resident had no delusions, behaviors, or mood problems. The resident required extensive assistance of 2 persons for bed mobility, toilet use, and extensive assistance of 1 person for locomotion on and off the unit. The resident required total assist with 2 persons for transfers and independent with setup assistance for eating and personal hygiene.

Review of the psychotropic drug CAA (care area assessment) dated 2/20/13 revealed the following: The resident was very anxious and nothing helped him/her with the anxiety. The nurse called the physician and received an order for Ativan 1 milligram (mg) by mouth (po) every 4 hours as needed for anxiety (PRN).

Review of the care plan dated 2/22/13, Moods and behaviors revealed that the resident had gotten discouraged because of his/her medical condition and the resident was upset. When the resident was admitted to the nursing home panic attacks started. Resident got sweaty, tearful, and felt as though he/she could not catch his/her breath. The staff administered the Ativan when

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that occurred. The resident took Halcion routinely so he/she could get sleep at night. The residents complained about the lack of sleep at night from anxiety. The care plan failed to provide guidance to the staff for the interventions prior to administering the hypnotic medication. No other interventions were care planned to help promote sleep prior to administering the Halcion.

On 3/28/13 staff obtained an order for Halcion 0.25 mg given po every night at bedtime for insomnia.

On 5/8/13 at 7:25 a.m., the resident sat in the recliner almost flat, sleeping soundly, cover on, and call light with in reach.

On 5/9/13 at 11:50 a.m., direct care staff E revealed that the resident preferred to sleep in the recliner. The resident just received the recliner and resident loved to sleep in it.

On 5/9/13 at 11:20 a.m., licensed nursing staff C revealed that the resident was alert and oriented and that the resident requested the sleep medication. The resident was to be a short term stay.

On 5/8/13 at 11:11 a.m., an interview with administrative nursing staff R revealed that care plans were started on admission and he/she was in charge of the care plans. Administrative nursing staff R reported that not all the problems care planned had individual problems such as falls, activities, but, tried to incorporate all the problems under headings such as mood/and behaviors.

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F 329	Continued From page 146 On 5/9/13 at 10:30 a.m. interview with administrative nursing staff K revealed consultant DD reviewed the pharmacy consultant reports (for gradual dose reductions, diagnosis, and serum levels of the medications,lab work for monitoring effectiveness) and mailed the reports in December 2012. When the reports did not come back to the facility nursing staff K notified the physician several times by phone. Nursing staff K sent a letter to get the physician to respond. The physicians finally responded to the pharmacist consultant report indicating the preferences in March 2013. On 5/13/13 at 10:27 a.m., pharmacy consultant DD revealed that the residents charts were looked at monthly and that he/she did not check all the charts for all things every month. The pharmacy consultant DD did not respond to questions asked of him/her for sleep hygiene monitoring and monitoring of the behaviors that included insomnia. The pharmacist consultant DD was not aware of the risk versus benefit statements the physician signed, (the benefit of taking the medications out weighed the risk of the side effects). The facility failed to ensure the resident #54 was free from unnecessary medications and failed to care plan interventions to help promote sleep. - Review of resident #5's physician's orders, signed on 5/6/13, identified the resident with the following diagnoses: irritable bowel syndrome (a disorder that leads to abdominal pain and cramping and changes in bowel movements), stress incontinence (involuntary urination due to	F 329		

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pressure on abdomen) constipation, diabetes mellitus, depressive disorder (a disorder characterized by persistent sadness or melancholy) and congestive heart failure (disease where the heart does not function properly).

Review of the Significant change MDS (Minimum Data Set-a required assessment) dated 3/18/13, revealed the resident had a BIMS (Brief Interview for Mental Status) score of 12/15 (indicated moderately impaired cognition), did not show any signs/symptoms of depression, had behavioral symptoms not directed toward others 1-3 days of the 7 day assessment period, frequently incontinent of urine that staff did not attempt a trial of a toileting program to relieve, and with a diagnosis of diabetes mellitus.

Review of the Psychotropic Medication Use CAA (Care Area Assessment-a further assessment) dated 3/22/13, revealed the physician gave an order for the resident to receive diazepam (an antianxiety) 10 mg (milligrams) po (by mouth) q (every) HS (bedtime) for treatment of neuropathy (a disease of the peripheral nerves). The CAA identified the resident had diabetes mellitus. The CAA also identified the resident had a diagnosis of neuropathy the CAA identified could be related to the diabetes mellitus. Staff documented in the CAA that the plan included for staff to administer the diazepam for neuropathy because the resident did not exhibit any significant side effects.

Review of the medication care plan, dated 1/2/13, revealed that since 3/22/13, the resident had taken Valium (an antianxiety medication) for treatment of the resident's neuropathy. The care

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plan also identified the resident took the following medications: Anusol HC-1 (medication for hemorrhoids), Aspirin, Diazepam, Glipizide (for diabetes mellitus), Januvia (for diabetes mellitus), Levothyroxine (thyroid hormone replacement included a black box warning for not to be used for weight loss), miraLax (encouraged routine bowel movements), Omeprazole (for gastric upset), Sertraline (antidepressant- Black box warning for clinical worsening and suicide risk), tums (for stomach upset), Tylenol and Vesicare (used for urinary incontinence). The care plan also identified on 4/4/13 that the resident took Zoloft (an antidepressant) routinely for depression with episodes of tearful outbursts. The medication care plan, attached to the care plan, addressed the medications with black box warnings. The care plan failed to identify the indications of use for each medication, so staff knew what to watch for.

Review of the physician's review of orders, signed on 5/6/13, revealed the physician ordered Omprezole 40 mg ordered for dyspepsia on 2/7/13. Looked at physician progress note dated 2/7/13: The patient is seen (2/8/13) for routine monthly visit. (The resident states he/she) is feeling pretty well and has no particular complaints except heartburn that (he/she) usually has at night and not unusual for (him/her). (He/she) used to take Omeprazole but is not getting it here (at the facility). (He/she) was taking 20 mg BID (twice a day). Review of the facility record revealed staff had not documented monitoring for nighttime heartburn.

Review of the physician's review of orders, signed on 5/6/13, revealed the physician ordered

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Diazepam 10 mg daily at HS on 6/12 for neuropathy. Review of the Drug Information Handbook for Nursing, 12th Edition revealed on page 405 that the use of "this drug may be inappropriate for use in geriatric patients." It identified the use of the medication was for the management of anxiety disorders, ethanol withdrawal symptoms; skeletal muscle relaxant, treatment of convulsive disorders, preoperative or preprocedural sedation and amnesia. On page 407, the book identified the appropriate doses for elderly/debilitated patients included 2 - 2.5 mg 1-2 times/day initially; increase gradually and as needed and tolerated. The staff never questioned the physician to clarify the indication for use of the drug. On 12/19/12, the facility sent a form to the physician asking for a dose reduction. The facility did not receive the form back from the physician until 4/4/13, and the physician approved the dose reduction--10 months after the resident had been on the medication.

Review of the physician's review of orders, signed on 5/6/13, revealed on 4/4/13, the physician ordered staff to administer Zoloft (an antidepressant) 25 mg po daily for depression--it did not identify what symptoms or behaviors the resident had that warranted the use of the medication or what staff were to monitor for. Last MDS completed on 3/18/13 revealed the resident did not have depression. Review of the May 2013 Behavior Monitoring sheet for psychotropic medications revealed the resident received the medication for depression. Day shift (6 am-2pm staff) identified the resident was observed with this on 5/4, evening shift (2pm-10pm) observed the resident with the behavior on 5/2, 4, and 6

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and night shift (10pm-6am) 2 times on 5/3, 4. The documentation lacked what depressive behaviors the resident exhibited, what triggers the resident exhibited (if any) or what staff did to help relieve the symptoms.

Review of the physician's review of orders, signed on 5/6/13, revealed on 12/14/12, the physician ordered the resident to have VESIcare (to help with urinary incontinence), and comparing the MDS from 12/19/12 with the MDS done on 3/18/13 revealed the resident's urinary incontinence has gotten worse, and the staff have not followed up with the physician to report. Staff failed to monitor the use of the medication.

On 5/7/13 at 3:10 p.m., observation of Direct care staff F and OO revealed the staff assisted the resident to the bathroom. Staff F and OO used a mechanical lift and removed the resident's incontinent brief. Observation of the brief revealed it was wet. Staff F and OO provided perineal care, then placed a clean brief on the resident, then propelled the resident still in the mechanical lift, out of the bathroom to the bed and assisted the resident to lie down before the evening meal. Staff F and OO were very polite with the resident.

On 5/7/13 at 12:03 p.m., Direct care staff E identified the resident really does have behaviors, he/she tries to stand up by himself/herself and then he/she falls. Staff E did not know what kinds of medicine the resident received "I am just a CNA (Certified Nurse's Aide), I am not a medication aide or anything like that."

On 5/8/13 at 3:18 p.m., Direct care staff F stated

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that he/she did not know what kinds of medications the resident received, or what he/she should be watching for.

On 5/9/13 at 12:45 p.m. Direct care staff M identified the resident got depressed--he/she will talk about what he/she used to be able to do, he/she starts to laugh and then you can tell he/she gets teary-eyed. Staff M said that he/she did not know how many times the resident had been upset before and if the antidepressant medication is working--he/she said this is new to him/her.

On 5/9/13 at 12:51 p.m. Licensed nursing staff J stated he/she did not really know about why the resident took Omeprazole, other than the resident was alert enough to let the staff know. As for the diazepam, staff J did not know why that the resident used neuropathy as a diagnosis--"it doesn't sound like a good diagnosis." Staff J confirmed that staff do not routinely ask the resident about pain in the legs--the staff wait until the resident said something about pain first. Staff J confirmed that the resident did not complaining of pain that staff J was aware of. Staff J looked in the nurse's notes and did not see anything in the nurses notes documented about pain, either.

On 5/9/13 at 2:51 p.m. Administrative nurse K stated the diazepam being used for neuropathy does sound odd and someone probably should have called about that. Nurse K admitted there have been some problems with documentation that they have identified and therefore they have recently started to assigning like 5 or 6 residents to one nurse and the nurse will go through the

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chart, talk with the resident the family and the doctor and make sure the information is in the chart, so hopefully things like this will be addressed. Nurse K identified that the facility had made attempts at dose reductions, but tried to complete all recommendations at once for all the residents in the facility on psychotropics to ask for dose reductions. Nurse K identified that overwhelmed the physicians with requests and the physicians did not respond timely. Nurse K stated the facility had to send several letters to the physicians to remind them a response was needed. Nurse K identified that was why the dose reductions were not attempted in a timely fashion.

Review of the facility's undated policy on Pharmacy and Therapeutic Agents, revealed it lacked guidance to staff on who was responsible for the monitoring of the medications, or who determined the indications for the use, or who analyzed the behavior monitoring data to determine if the psychoactive medications remained necessary.

The facility failed to adequately monitor an antidepressant medication, failed to monitor, obtain an adequate indication for use and request a gradual dose reduction for the use of diazepam, failed to monitor the use of Omeprazole, and failed to monitor and report the use of a medication to help with urinary incontinence for one resident to ensure the medications' necessity.

- Review of the physician's review of orders for resident #40, signed on 5/1/13, revealed the resident had the following diagnoses: Left-sided

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hemiplegia (paralysis on the left side), joint contracture (chronic loss of joint movement due to structural changes in non-bony tissue) of the left upper arm, forearm, and hand, and dementia (progressive disease with marked cognitive loss).

Review of the annual MDS (Minimum Data Set-a required assessment) dated 4/29/13, identified the resident with a BIMS (Brief Interview for Mental Status) score of 2/15 (indicated severely impaired cognition), had physical behaviors 1-3 days of the 7 day assessment period, received antipsychotic and antidepressant medications all 7 days of the 7-day assessment period.

Review of the Behavioral Symptoms CAA (Care Area Assessment) dated 5/1/13 revealed the resident has a diagnosis of dementia, and the resident's normal status was confused, forgetful and easily distracted. The CAA identified staff monitored the increased behaviors but at that time staff had not noticed any changes. The CAA identified the resident had depression with resistance of care, and took Zoloft (an antidepressant) routinely for the depression. The CAA also identified the resident took Seroquel (an antipsychotic) for dementia with behaviors of refusing care and wandering. The CAA identified the staff monitored the resident for behaviors and redirected when possible.

Review of the Psychotropic Medication Use CAA, dated 5/1/13, revealed the resident had depression with resistance of care and took Zoloft routinely for the depression. The CAA also identified the resident took Seroquel (an antipsychotic) for dementia with behaviors of refusing care and wandering. The CAA identified

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the staff monitored the resident for behaviors and redirected when possible. The CAA identified the resident has been on those medications with no complications noted, and the doctor reviewed the medications every six months at least.

Review of the care plan, dated 5/2/13, revealed the the resident wandered in the facility and rummaged through things frequently. The resident also tried to exit the doors and go into other resident's rooms. At night the resident had disrobed would take all covers and throw them to the floor then try to use the pads on the bed to cover up. The resident also "picks apart" the incontinent brief, grabbed the aides' arms and pushed the aides against the wall resisting care at night. The care plan directed staff to redirect the resident from entering other resident's rooms. The resident also received Zoloft that he/she took for depression and Seroquel for resisting care.

Review of the undated pocket sheets, used as a shortened care plan or "cheat sheets" for the direct care staff to carry with them failed to identify any behaviors the resident had, or give guidance to staff on how to handle the behaviors.

Review of the April 2013 behavior sheets revealed that the resident received Seroquel and Zoloft for refusal of care. Staff documented that the resident exhibited those behaviors on day shift (6am-2pm staff) on 4/28, evening shift (2pm-10pm staff) on 4/14, 16, 21, and 28, and on night shift (10pm-6am staff) on 4/14 and 15. Review of the nurse's notes revealed a lack of what the resident triggers were for the refusal of care, or what staff did to handle the behaviors. The record lacked an analysis of the behaviors to

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see if the Seroquel or Zoloft is working, and the record lacked a risk versus benefit statement from the physician to justify the continued use of the medications at the doses. The record revealed no gradual dose reduction had been attempted for either medication.

The facility utilized a sheet of the all the medications the resident had orders for, the potential side effects of the continued use of each medication, and then a question after each medication asking the physician if he/she wanted a dose reduction. The facility sent the form to the physician in December 2012. The physician reviewed and answered the sheet on 3/14/13--the physician just circled "no" to the dose reduction question for both the Zoloft and the Seroquel.

On 5/7/13 at 11:57 a.m., 2 nurse aides, Direct care staff E and LL entered the resident's room, transferred the resident out of the recliner and into a wheelchair. Direct care staff LL then propelled the resident to the dining room where he/she then transferred the resident to a regular chair in the dining room, then left the resident in the chair. The resident never tried to resist the care provided by the staff.

On 5/7/13 at 12:03 p.m., Direct staff E stated the resident did not have any behaviors other than the wandering. Staff E stated that occasionally the resident hit, but that happened during like bath times, when the resident did not want to take a bath.

On 5/9/13 at 1:45 p.m. Licensed nursing staff J identified the resident's only behavior was wandering, and that had pretty much stopped

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when staff now transferred the resident into a his/her recliner and the regular chair in the dining room.

On 5/9/13 at 2:51 p.m. Administrative nurse K admitted there have been some problems with documentation that they have identified and therefore the facility recently started to assign like 5 or 6 residents to one nurse and the nurse would go through the chart, talk with the resident the family and the doctor and make sure the information is in the chart, so hopefully things like this will be addressed. Nurse K identified that the facility had made attempts at dose reductions, but tried to complete all recommendations at once for all the residents in the facility on psychotropics to ask for dose reductions. Nurse K identified that overwhelmed the physicians with requests and the physicians did not respond timely. Nurse K stated the facility had to send several letters to the physicians to remind them a response was needed. Nurse K identified that was why the dose reductions were not attempted in a timely fashion.

Review of the facility's undated policy on Pharmacy and Therapeutic Agents, revealed it lacked guidance to staff on who was responsible for the monitoring of the medications, or who determined the indications for the use, or who analyzed the behavior monitoring data to determine if the psychoactive medications remained necessary.

The facility failed to adequately monitor, attempt gradual dose reductions, or obtain a risk versus benefit statement for the continued use of 2 psychotropic medications for a resident.

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F 329	Continued From page 157 - Review of resident #59's signed physician order sheet dated 4-11-13 included the following diagnoses: Bilateral Subdural hematoma (a collection of blood below the inner layer of the dura but external to the brain and arachnoid membrane), Dementia (progressive mental disorder characterized by failing memory, confusion) with behaviors/ agitation, and insomnia (inability to sleep). Review of the face sheet revealed an admission date of 4-12-13. Review of the admission MDS (Minimum Data Set 3.0, a required assessment) dated 4-22-13 revealed a BIMS (Brief Interview for Mental Status) score of 2 that indicated severe cognitive impairment. It also revealed the resident had difficulty focusing, was easily distracted, and had disorganized thinking that fluctuated throughout the day. The MDS also revealed the resident had physical and verbal behaviors toward others, and behaviors not directed at others (scratching self, screaming out, inappropriate gestures, or sexual acts, disruptive sounds) 1-3 days out of past 7. It also revealed the resident had a fall in the past 6 months prior to admission to the facility and had 2 falls since admission. It revealed the resident required extensive assistance of 1 for all cares except for walking in room required limited assistance and used a wheelchair for mobility. The MDS also revealed the resident was not steady but able to stabilize without staff assistance with transfer, turning around, or moving on and off the toilet. It also revealed the resident had moderately impaired vision and could not read the newspaper headlines but could identify objects.	F 329		

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Review of the Visual Function CAA (Care Area Assessment) dated 4-23-13 revealed the resident had macular degeneration and considered to be blind. Staff pushed the resident in the wheelchair in the halls, and provided extensive assistance with eating and dressing. The resident did not wear his/her glasses because they did not help so they were left at home.

Review of the Psychosocial Well-Being CAA dated 4-23-13 revealed the resident resisted assistance with care and reported being depressed. The resident received Remeron for depression, Nortriptyline for insomnia and behaviors and Ativan as needed for increased anxiety.

Review of the Behavioral Symptoms CAA dated 4-23-13 revealed the resident frequently stood from the wheelchair without assistance, was very unsteady, and needed assistance of staff. It also revealed the resident resisted care to the point of hitting and kicking at times. The resident reported he/she was depressed and would be better off dead but would not hurt self. The resident had used Ativan as needed for increased anxiety, Remeron for depression, and Nortriptyline for insomnia and behaviors.

Review of the care plan dated 4-24-13 revealed the resident had problems with impulse control and would try and get up unassisted. It directed staff to walk or push the resident in wheelchair to help calm the resident. It also revealed the resident had agitation and tried to hit staff, resisted assistance from staff, had inappropriate verbalizations and actions toward caregivers of a certain gender, and poor sleep patterns. The care

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F 329	Continued From page 159 plan included the resident had sad thoughts and received Remeron for depression, Nortriptyline due to insomnia and inappropriate behaviors. The care plan lacked interventions for staff to use to help the resident sleep, help in managing the resident's behaviors, and to monitor insomnia. Review of the behavior monitoring sheets included one for Nortriptyline for depression. It lacked the monitoring for insomnia which was the indication for it's use. Review of the resident behavior monitoring on electronic record lacked any documentation of monitoring for insomnia. Review of the NN (Nurse's Notes) dated 4-12-13 at 11:00 p.m. revealed the resident became agitated with staff and remained agitated and combative at 11:30 p.m. It revealed staff offered toileting, position change, food, and drink all without success. Ativan, a medication for anxiety, was then administered topically. Review of the NN dated 4-15-13 at 10:15 p.m. revealed the resident wandered into other resident rooms, attempted to stand by self, staff pushed resident in wheelchair until 11:45 p.m. The resident denied being tired, and then wheeled in wheelchair until 12:30 a.m. Resident became upset and red faced, attempted to take apart wheelchair, threw food at staff when offered a snack, and would go in and out of other resident rooms. Staff tried different activities but did not help and needed on-on-one supervision/care until 2:00 a.m. when the resident calmed down and ate a sandwich.	F 329		

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Review of the NN dated 4-15-13 revealed the resident spit at staff, then sat calmly in chair until 2:20 a.m. Resident then became agitated, tried to throw the wheelchair and stool riser, got upset with staff of a specific gender and made inappropriate comments.

Review of the NN dated 4-19-13 revealed orders to increase nortriptyline to 20 milligrams daily.

Review of the NN dated 4-20-13 revealed the resident had a restful night.

An observation on 5-7-13 at 11:37 a.m. revealed the resident lay in bed on his/her back.

An observation on 5-8-13 at 11:25 a.m. showed direct care staff AA pushed the resident back to his/her room from the dining room table. The resident sat in his/her wheelchair with a cushion.

During an interview on 5-9-13at 9:52 a.m. direct care staff EE reported the behavior monitoring sheets on the MAR (Medication Administration Sheets) are just to record if the resident did or did not have those specific behaviors for that day. He/she reported that he/she asked the aides toward the end of the shift about behaviors and the aides also documented in the computer if the resident had any behaviors.

During an interview on 5-9-13 at 3:01 p.m. direct care staff W reported if the resident was restless he/she would put on polka music, take the resident to the bathroom, reposition the resident, and may get him/her up and take to the nurse ' s station.

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During an interview on 5-9-13 at 3:03 p.m. licensed nurse staff FF reported things staff do for the resident if restless varied depending on the nurse. Staff FF reported the resident rested better if he/she had a full belly, staff kept the hall quiet, and would also get the resident up for a while and then take him/her back to bed.

During an interview on 5-9-13 at 3:29 p.m. Administrative nursing staff K reported that he/she would expect if someone was taking a medication for insomnia the nurses would be documenting in the nurses notes how it was or was not working. Staff K reported it would be something staff should have on the MAR to monitor if resident had insomnia so they would be able to tell if it was working or not.

The facility failed to develop and implement a plan to attempt non-pharmacological interventions to help a resident who received Nortriptyline for insomnia.

- Review of the quarterly MDS (Minimum Data Set-a required assessment) dated 12-3-12 revealed resident #18 had a BIMS (Brief Interview for Mental Status) score of 10 indicating the resident had moderate cognitive impairment, had a mood score of 3 indicating the resident had trouble falling to sleep, required limited assistance of one staff for bed mobility, transfers, and extensive assistance of one staff for dressing, toilet use, and personal hygiene, supervision setup assistance with eating, took an antipsychotic, antidepressant, and diuretic for all 7 of the 7 day look back period.

Review of the resident's annual MDS dated

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2-25-13 revealed a BIMS score of 8 indicating the resident had moderate cognitive impairment, required one staff assistance with dressing, toilet use and personal hygiene, setup assistance with eating, had no behaviors such a hallucinations or delusions, a mood score of 0, took an antipsychotic, antidepressant, and diuretic for all 7 of the 7 day look back period.

Review of the cognitive loss CAA (care area assessment) dated 2-28-13 revealed the resident had dementia, behaviors of inappropriate verbalizations, and poor impulse control, tended to yell at others, likes to go to activities to participate and socialized with others.

Review of the psychotropic drug use CAA dated 2-28-13 revealed the resident was placed on Seroquel(an antipsychotic) because he/she would not sleep but would just walk, and now he/she no longer wanders aimlessly but instead, has inappropriate verbalizations and poor impulse control. The resident takes Xanax three times daily for anxiousness and Cymbalta for depression. At that time the resident did not show any complications from the doses of psychotropic medications.

Review of the care plan dated 3-5-13 for ADL'S(activities of daily living) revealed the resident needed help with daily cares, able to transfer himself/herself and did his/her own bed mobility, chose to sleep in the recliner, could walk independently with no assistive device, needed assistance to get dressed and perform personal hygiene including perineal care, needed prompted to use the toilet when he/she got up, incontinent of bowel and bladder often, would like

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a shower 2 times weekly, needed assistance to brush dentures, and did not like to wear bottom dentures.

Review of the care plan for moods and behaviors dated 3-5-13 revealed the resident had depression, anxiety, and vascular dementia, had been to a behavioral health unit in the past, used to wander and not talk at all, had sad pained worried facial expressions, was placed on Cymbalta which did help with mood, was placed on Seroquel which helped the resident to stop wandering. The resident does have some inappropriate verbalizations and spoke his/her mind very loudly.

Review of the care plan for medication management dated 2-19-12 revealed the resident took
an antipsychotic and antidepressant.

Review of the psychotropic drug assessment dated 2-28-13 revealed the resident took Cymbalta, Seroquel, and Xanax and has had no side effects.

Review of the physician's orders dated 4-4-13 revealed an order to discontinue Xanax(antianxiety) with the reason of non use.

Review of a communication form from the pharmacy to the physician dated 8-21-2012 revealed a request for the physician to review the current antipsychotic and antidepressant medications and indicated there had not been a gradual dose reduction attempted in the last 6 months.

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Review of a communication letter from the facility to the physician dated January 2013, revealed a request to the physician to complete the forms for review of the medications which were sent in December 2012. Some of the medications listed needed supportive documentation (as per the federal guidelines) for a gradual dose reduction or supportive documentation to continue the same dose as prescribed.

An observation on 5-8-13 at 7:23 a.m. of the resident seated at the breakfast table revealed the resident ate pancakes while the nurse gave the medications. The resident received his/her pills crushed and mixed in applesauce per request and took them without difficulty.

In an interview on 5-9-13 at 11:24 a.m. Administrative Nursing K reported there were communication letters sent to the physician every six months with requests for a review of all the medications for the resident including choices for either dose reductions or supportive documentation to continue the same dose and medication regimen. Staff K confirmed the physician had not filled out the form sent in August 2012 and again in December 2012. Staff K confirmed there had been no dose reductions for this resident in the last year from April 2012 to April 2013 and the facility is responsible to continue to communicate with the physician to complete the documentation.

In an interview on 5-13-13 at 10:22 a.m. pharmacist DD reported per federal guidelines the resident should have a gradual dose reduction attempt at least every 6 months on specific medications including antipsychotics and

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F 329	Continued From page 165 antidepressants. The facility failed to ensure the resident's medications for antipsychotic and antidepressant medications were reviewed and a gradual dose reduction was attempted and/or supportive documentation for continuance of the medications was completed for the benefit of the resident's health and psychological well being.	F 329		
F 353 SS=F	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: The facility census totaled 50 residents. Based	F 353		

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on observation, interview, record review, and quality of care deficiencies cited during the survey that ended 5/20/13, the facility failed to provide adequate supervision to the temporary nursing staff to ensure the related services were provided to the residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident as determined by the assessments and care plans. This had the potential to affect all 50 residents.

Findings included:

- On 5/8/13 at 4:18 p.m., observation revealed Direct care staff PP-a temporary staff memory-entered the room of resident #40 without knocking. Staff PP told the confused resident he/she was trying to learn who the residents were, as this was his/her second time at the facility. Staff PP read the resident's information off the sheets that the facility staff gave to Staff PP at the beginning of the shift 2 hours prior. Staff PP placed the resident's wheelchair near the recliner and then applied gloves. Staff PP then approached the resident and said "You are going to have to direct me (resident's name). Are you able to stand with one person assist?" The confused resident said "Pardon me?" and the aide repeated the question. The resident did not answer Staff PP, but staff PP started to attempt to transfer the resident independently. The surveyor stopped staff PP and told him/her that observations done earlier in the day had involved 2 staff and a transfer gait belt. Staff PP said ok, and left the room to go find help.

During an interview on 5/7/13 at 3:13 p.m., direct care staff II and direct care staff JJ, both

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temporary workers, reported the facility had placed copies of the care plans in the rooms of each resident. Staff II and JJ also identified they were given a "cheat sheet" to follow on how to care for the residents. Staff II reported that on the first day they had come to the facility, the facility staff tried to take the temporary staff around the facility and show them where everything was. Staff II and JJ reported the first day in the facility, they received a "little more" of a report than on other days. When asked about any training they had received, staff II reported most facilities had a book at the nurse's station for emergency situations but all other training they received from their temporary work agency. Staff II reported that when he/she came the first time, the other workers from the facility staff did not have time to show him/her around.

During an interview on 5/7/13 at 4:01 p.m., Administrative Nurse K reported the facility did not have a policy regarding temporary staffing. He/she reported temporary staff are provided "cheat sheets" for each hall that had basic needs of each resident on it as well as the nurses were to talk to them about the residents and any specific concerns. When asked what other type of training the facility provided Staff K reported all other training was provided by the temporary agency.

On 5/8/13 at 6:33 p.m., Licensed nursing staff O stated he/she did not know who actually trained the temporary staff to make sure they knew the facility's expectations. Staff O said that he/she gave the temporary workers the care plan pocket sheets and expected them to follow sheets, just like the facility's own staff. Staff O said that when

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there are too many temporary staff, he/she did not have the time to get his/her responsibilities done, plus follow up behind each of the staff to ensure they followed the plan of care for the residents, so he/she has to rely on them to do what the pocket sheets say.

On 5/9/13 at 12:51 p.m., Licensed nursing staff C reported that when supervising staff it could be difficult, "especially when there was only one nurse for both halls." Staff C reported that sometimes the nurse just had to look side to side when he/she walked the halls to see in the rooms and ask the staff if the care had been completed.

On 5/9/13 at 1:18 p.m. Licensed nursing staff J stated he/she expected the other nurse aides to tell the temporary staff what the different alarms meant, like which ones are the door alarms, which ones are chair alarms, all that. Staff J expected the facility's full-time staff to work with the temporary staff to try and train them as much as they can. However, staff J identified for the most part, most of the temporary staff that worked at the facility had worked there for several months and were "pretty familiar" with the residents by now.

Review of the Resident Council Concerns dated 3/5/13 revealed that the residents present at the meeting identified the concern that aides took too long to answer call lights. The residents identified the staff came into the rooms and told the residents they had to wait, that the staff would be back when they had time. The residents stated that they then waited but it took up to 1 hour before anyone came back.

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Review of the Resident council minutes from 4/2/13 revealed that the residents had invited Administrative Nurse K to the meeting. The residents told Staff K that some of the aides were not good, and they had concerns as the CNAs (Certified Nurse Aides) were telling the residents that they are "making up" that they have to go to the bathroom. Staff K told the residents that all staff would watch a video on abuse, and then Staff K would check in with the residents next month to see if the concern was better.

Review of the nursing schedule revealed the following:
On 5/1/13 for day shift (6am-2pm), 1 of the 5 direct care staff were temporary staff. On 2nd shift (2pm-10pm), 3 of the 6 direct care staff were temporary, and 3rd shift (10pm-6am) 1 of the 3 direct care staff were temporary staff.

On 5/2/13 for for the day shift, 1 of the 2 direct care staff that passed medications were temporary staff, for the 2nd shift, 3 of the 4 direct care staff were temporary staff and on the 3rd shift, 1 of the 3 direct care staff were temporary staff.

On 5/3/13, on 2nd shift 2 of the 5 direct care staff were temporary staff, and for the 3rd shift, 2 of the 3 direct care staff were temporary.

On 5/4/13, on day shift 1 of the 5 direct care staff were temporary, on 2nd shift 1 of the 5 direct care staff were temporary, and on the 3rd shift, 2 of the 3 direct care staff were temporary.

On 5/5/13, on day shift 1 of the 6 direct care staff scheduled were temporary, on 2nd shift, 1 of the

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F 353	Continued From page 170 5 direct care staff were temporary, and the 3rd shift, 2 of the 3 scheduled were temporary. On 5/6/13, on day shift 1 of 5 direct care staff were temporary. On 2nd shift, 2 of the 5 direct care staff were temporary, and for the 3rd shift, all 3 of the direct care staff were temporary staff. On 5/7/13 on day shift, 2 of the 5 direct care staff were temporary, 2nd shift 5 of the 6 direct care staff were temporary, and for 3rd shift, 1 of the 3 direct care staff were agency. The schedule also revealed normal staffing patterns for licensed charge nurses revealed the facility planned 2 nurses for both the day shift and the evening shift, and one on the night shift. According to the schedule, the facility only had 1 charge nurse scheduled for the day shift on 5/2, 3, 4, 5, 6 and 7/13. During an discussion on 5/13/12 at 8:30 a.m. with 4 Administrative staff present, the surveyors discussed the following concerns which indicated a lack of sufficient supervision to meet the resident's needs: 1) Concerns regarding the lack of activities for residents with dementia and wandering tendencies. See F248 for further details. 2) Concerns regarding the lack of positioning needs for residents with tendencies to lean, a failure to protect the fragile skin a resident at risk for skin tears, and the lack of monitoring of a fistula site after a resident had dialysis. See F309 for further details.	F 353		

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F 353	Continued From page 171 3) Concerns regarding recognizing the changed needs for a resident with a newly fractured arm. The staff failed to assist the resident to reposition as frequently as needed, and the resident develop a pressure ulcer on a heel. See F314 for further details. 4) Concerns regarding the failure to assess and implement the planned toileting services for 2 residents. See F315 for further details. 5) Concerns regarding the staff's failure to develop and implement interventions to prevent falls for a resident. See F323 for further details. 6) Concerns regarding the staff's failure to encourage fluids as ordered. See F327 as ordered. 7) Concerns regarding the staff's failure to monitor medications and obtain gradual dose reductions for psychoactive medications in a timely basis. See F329 for further details. The facility failed to provide sufficient nurse supervision to ensure staff provided the services needed for each resident to maintain his/her highest practicable physical, mental, and psychosocial well-being.	F 353		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		

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This REQUIREMENT is not met as evidenced by:
The facility census totaled 50 residents. The kitchen prepared and served food and drinks for all 50 residents. Based on observation, interview and record review, the facility failed to provide the necessary cleaning services of the ice cream machine, juice machine and vent screens to ensure prepare and serve food under sanitary conditions. This had the potential to affect all 50 residents.

Findings included:

- On 5/8/13 at 9:38 a.m., observation revealed a filter above the steam table in the kitchen evidenced a large buildup of dust/dirt, rendering the filter a brown color with strings of dust/dirt visible. Dietary staff P at that time acknowledged that the filter above the steam table/food prep area as very dirty. Staff P stated maintenance changed the filter weekly, and it was just done last Wednesday, and maintenance planned to change it again today.

On 5/8/13 at 11:07 a.m., observation revealed the filter over the steam table in the kitchen was gone. Maintenance staff Q brought in a bright blue filter at that time and prepared to place it over the steam table. When asked if the screen was new, Staff Q stated no, that he/she had cleaned the filter like he/she did every week. When told if the filter got so dirty in a week's time

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that it covered the color of the filter, perhaps staff could clean the filter more frequently than weekly, Maintenance staff Q just smiled.

The facility failed to ensure the cleanliness of the filter about the steam table from which staff served food to the residents.

- On 5/8/13 at 9:43 a.m., observation revealed the facility had a juice dispenser machine the dietary staff used to serve the residents juice from. The facility also had a soft-serve ice cream machine in the dining room, also, which staff used to serve the residents ice cream at any time.

On 5/8/13 at 10:50 a.m., observation revealed a dietary staff member cleaned the ice cream machine. Dietary staff D and P identified the staff deep cleaned the juice and ice cream machine weekly, and provided a sheet that identified the cleaning schedule of the dietary department.

Review of the manufacturer's guidelines for cleaning and sanitizing the juice machine revealed the guidance recommended a daily, weekly, and semi-annual cleaning schedule.

Review of the manufacturer's guidelines for cleaning the ice cream machine revealed the guidance recommended a daily, monthly, quarterly and annual cleaning schedule to retard the growth of bacteria.

Review of the dietary's cleaning schedule, last revised on 11/19/12, revealed the staff cleaned the ice cream machine weekly on Wednesdays. The cleaning schedule lacked the cleaning of the juice machine, but Dietary staff D stated that staff

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F 371	Continued From page 174 cleaned the juice machine weekly, also. The facility failed to clean the juice and ice cream machine as frequently as recommended by the manufacturers to resist the growth of bacteria. This had the potential to affect all 50 residents.	F 371		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: The facility census totaled 50 residents with 21 residents sampled. The sample included the review of the medication regimen for 10 residents. Based on observation, interview, and record review, the pharmacist failed to identify irregularities in the medication regimen for 3 of 10 residents sampled for unnecessary medications. (#5, #40, and #59) Findings included: - Review of the May 2013 MAR (Medication Administration Record) for resident #5 revealed the resident received the medications Zoloft for depression, VESIcare for urinary incontinence,	F 428		

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omeprazole for dyspepsia (stomach upset), and diazepam (an antianxiety) for neuropathy (disease of the peripheral nerves).

Observation of the medical record revealed the resident had been taking Zoloft and diazepam for over 6 months and there had not been a gradual dose reduction, nor had the physician written a risk versus benefit statement. Staff also were not adequately monitoring the use of Zoloft, diazepam, VESIcare or omeprazole. Staff also had not clarified the indications for the use of diazepam.

Review of Consultant DD's monthly reviews revealed Consultant DD had identified no irregularities in the resident medication regimen in the months of January, February, March and April 2013.

On 5/9/13 at 2:51 p.m. Administrative nurse K stated the diazepam being used for neuropathy did sound odd and someone probably should have called about that. Nurse K admitted there have been some problems with documentation that they have identified and therefore they have recently started to assigning like 5 or 6 residents to one nurse and the nurse will go through the chart, talk with the resident the family and the doctor and make sure the information is in the chart, so hopefully things like this will be addressed. Nurse K identified that the facility had made attempts at dose reductions, but tried to complete all recommendations at once for all the residents in the facility on psychotropics to ask for dose reductions. Nurse K identified that overwhelmed the physicians with requests and the physicians did not respond timely. Nurse K

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stated the facility had to send several letters to the physicians to remind them a response was needed. Nurse K identified that was why the dose reductions were not attempted in a timely fashion.

On 5/13/13 at 9:30 a.m., Consultant DD identified that he/she had seen diazepam being given for neuropathy before and did not believe that was an irregularity, which was why he/she had not identified it as such. Consultant DD stated that he/she did not review the medical records to ensure the facility was monitoring each medication, he/she assumed the facility was doing that. As for the gradual dose reductions, Consultant DD was unaware of the need of a risk versus benefit statement if the physician did not want to attempt a gradual dose reduction after the first 6 months of being on a psychoactive medication.

The facility's pharmacist failed to recognize irregularities in a resident's medication regimen and failed to notify the Director of Nurses and the physician of the irregularities.

- Review of the May 2013 MAR (Medication Administration Record) for resident #40 revealed the physician had ordered staff to administer Zoloft (an antidepressant) and Seroquel (an antipsychotic) to the resident daily. The facility identified the indications for use for both of the medications included the behavior of resisting care.

Review of the behavior monitoring sheets revealed staff did monitor the resident for resisting care on a monthly basis, per shift. The

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resident had between 2-6 episodes of resisting care per shift, per month. The medical record lacked analysis of the monitoring to determine the continued need for either medication or for the medications' effectiveness.

On 5/9/13 at 2:51 p.m. Administrative Nurse K admitted there had been some problems with documentation that they have identified and therefore they have recently started to assigning like 5 or 6 residents to one nurse and the nurse will go through the chart, talk with the resident the family and the doctor and make sure the information is in the chart, so hopefully things like this will be addressed. Nurse K identified that the facility had made attempts at dose reductions, but tried to complete all recommendations at once for all the residents in the facility on psychotropics to ask for dose reductions. Nurse K identified that overwhelmed the physicians with requests and the physicians did not respond timely. Nurse K stated the facility had to send several letters to the physicians to remind them a response was needed. Nurse K identified that was why the dose reductions were not attempted in a timely fashion.

On 5/13/13 at 9:30 a.m., Consultant DD stated that he/she did not review the medical records to ensure the facility was monitoring each medication, he/she assumed the facility was doing that. As for the gradual dose reductions, Consultant DD was unaware of the need of a risk versus benefit statement if the physician did not want to attempt a gradual dose reduction after the first 6 months of being on a psychoactive medication.

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The facility's pharmacist failed to recognize irregularities in a resident's medication regimen and failed to notify the Director of Nurses and the physician of the irregularities.

- Review of resident #59's signed physician order sheet dated 4-11-13 included the following diagnoses: Bilateral Subdural hematoma (a collection of blood below the inner layer of the dura but external to the brain and arachnoid membrane), Dementia (progressive mental disorder characterized by failing memory, confusion) with behaviors/ agitation, and insomnia (inability to sleep). Review of the face sheet revealed an admission date of 4-12-13.

Review of the admission MDS (Minimum Data Set 3.0, a required assessment) dated 4-22-13 revealed a BIMS (Brief Interview for Mental Status) score of 2 that indicated severe cognitive impairment. It also revealed the resident had difficulty focusing, was easily distracted, and had disorganized thinking that fluctuated throughout the day. The MDS also revealed the resident had physical and verbal behaviors toward others, and behaviors not directed at others (scratching self, screaming out, inappropriate gestures, or sexual acts, disruptive sounds) 1-3 days out of past 7. It also revealed the resident had a fall in the past 6 months prior to admission to the facility and had 2 falls since admission.

Review of the Psychosocial Well-Being CAA dated 4-23-13 revealed the resident resisted assistance with care and reported being depressed. The resident received Remeron for depression, Nortriptyline for insomnia and behaviors and Ativan as needed for increased

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F 428	Continued From page 179 anxiety. Review of the Behavioral Symptoms CAA dated 4-23-13 revealed the resident frequently stood from the wheelchair without assistance, was very unsteady, and needed assistance of staff. It also revealed the resident resisted care to the point of hitting and kicking at times. The resident reported he/she was depressed and would be better off dead but would not hurt self. The resident had used Ativan as needed for increased anxiety, Remeron for depression, and Nortriptyline for insomnia and behaviors. Review of the care plan dated 4-24-13 revealed the resident had problems with impulse control and would try and get up unassisted. It directed staff to walk or push the resident in wheelchair to help calm the resident. It also revealed the resident had agitation and tried to hit staff, resisted assistance from staff, had inappropriate verbalizations and actions toward caregivers of a certain gender, and poor sleep patterns. The care plan included the resident had sad thoughts and received Remeron for depression, Nortriptyline due to insomnia and inappropriate behaviors. The care plan lacked interventions for staff to use to help the resident sleep, help in managing the resident's behaviors, and to monitor insomnia. Review of the behavior monitoring sheets included one for Nortriptyline for depression. It lacked the monitoring for insomnia which was the indication for it's use. Review of the resident behavior monitoring on electronic record lacked any documentation of monitoring for insomnia.	F 428		

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Review of the NN (Nurse's Notes) dated 4-12-13 at 11:00 p.m. revealed the resident became agitated with staff and remained agitated and combative at 11:30 p.m. It revealed staff offered toileting, position change, food, and drink all without success. Ativan, a medication for anxiety, was then administered topically.

Review of the NN dated 4-15-13 at 10:15 p.m. revealed the resident wandered into other resident rooms, attempted to stand by self, staff pushed resident in wheelchair until 11:45 p.m. The resident denied being tired, and then wheeled in wheelchair until 12:30 a.m. Resident became upset and red faced, attempted to take apart wheelchair, threw food at staff when offered a snack, and would go in and out of other resident rooms. Staff tried different activities but did not help and needed on-on-one supervision/care until 2:00 a.m. when the resident calmed down and ate a sandwich.

Review of the NN dated 4-15-13 revealed the resident spit at staff, then sat calmly in chair until 2:20 a.m. Resident then became agitated, tried to throw the wheelchair and stool riser, got upset with staff of a specific gender and made inappropriate comments.

Review of the NN dated 4-19-13 revealed orders to increase Nortriptyline to 20 milligrams daily.

Review of the NN dated 4-20-13 revealed the resident had a restful night.

An observation on 5-7-13 at 11:37 a.m. revealed the resident lay in bed on his/her back.

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F 428	Continued From page 181 An observation on 5-8-13 at 11:25 a.m. showed direct care staff AA pushed the resident back to his/her room from the dining room table. The resident sat in his/her wheelchair with a cushion. During an interview on 5-9-13 at 9:52 a.m. direct care staff EE reported the behavior monitoring sheets on the MAR (Medication Administration Sheets) are just to record if the resident did or did not have those specific behaviors for that day. He/she reported that he/she asked the aides toward the end of the shift about behaviors and the aides also documented in the computer if the resident had any behaviors. During an interview on 5-9-13 at 3:01 p.m. direct care staff W reported if the resident was restless he/she would put on polka music, take the resident to the bathroom, reposition the resident, and may get him/her up and take to the nurse's station. During an interview on 5-9-13 at 3:03 p.m. licensed nurse staff FF reported things staff do for the resident if restless varied depending on the nurse. Staff FF reported the resident rested better if he/she had a full belly, staff kept the hall quiet, and would also get the resident up for a while and then take him/her back to bed. During an interview on 5-9-13 at 3:29 p.m. Administrative nursing staff K reported that he/she would expect if someone was taking a medication for insomnia the nurses would be documenting in the nurses notes how it was or was not working. Staff K also reported it would be something staff should have on the MAR to	F 428		

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F 428	Continued From page 182 monitor if resident had insomnia so they would be able to tell if it was working or not. During an interview on 5-13-13 at 10:27 a.m. consultant DD reported they did not always look at the monitoring of behaviors or insomnia medications every month. The Pharmacist failed to identify irregularities regarding the monitoring of effectiveness in a medication used for insomnia.	F 428		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of	F 431		

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controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by:
The facility census totaled 50 residents. Based on observation, interview, and record review, the facility failed to ensure the insulin used for 3 diabetic residents and 2 open vials of TB testing solution remained within date and not expired. This had the potential to affect 3 diabetic residents and any resident that required testing for TB, either for routine testing or symptomatic testing.

Findings included:

- Observation on 5/6/13 at 8:07 a.m. of the facility's only medication room revealed the following:

An opened vial of Lantus insulin for resident #8 that staff documented was opened on 4/2/13. Administrative Nurse L confirm the insulin was expired and should have been pulled.

An opened vial of Levimir insulin for resident #53 that staff dated as opened on 4/2/13. Administrative Nurse L said that it was expired and should have been pulled.

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F 431	Continued From page 184 An opened vial of Lantus for resident #42 that staff dated as opened on 3/11/13 and had written the expiration date of 4/9/13. Administrative Nurse L confirmed that it should have been pulled. 2 open vials of Tubersol (TB testing solution)--not dated. Administrative Nurse L said the staff use the expiration date of vial stamped on the box. Administrative Nurse L did not know if the expiration date was altered once the vial was opened or not. . At that time, Administrative Nurse L identified the responsibility of going through the medications to remove all expired medications fell to the evening nurse. Review of the manufacturer's guidelines for the Tubersol revealed the following: A VIAL OF TUBERSOL WHICH HAS BEEN ENTERED AND IN USE FOR 30 DAYS SHOULD BE DISCARDED BECAUSE OXIDATION AND DEGRADATION MAY HAVE REDUCED THE POTENCY. Review of the facility's policy on Tuberculosis, dated 12/11, revealed the following: 2. All tuberculosis vials will be labeled with an open date and expiration date when opened. 4. Expiration dates should be noted prior to drawing up medication. Review of the facility's policy on Insulins, dated 12/11, revealed the following: All insulin vials will be labeled with an open date and expiration date when opened. Expiration dates should be noted prior to drawing	F 431		

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F 431	Continued From page 185 up medication. The facility failed to ensure 3 insulin vials and 2 vials of TB testing solution remained within date.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens	F 441		

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F 441	Continued From page 186 Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: The facility census totaled 50 residents with 21 included in the sample. Based on observation, interview, and record review, the facility failed to have an infection control program that addressed how to prevent the transmission of shingles and failed to have a physician's order for isolation for 1 of 21 residents sampled due to isolation. (#5) Findings included: - Review of resident #5's physician's orders, signed on 5/6/13, identified the resident with the following diagnoses: irritable bowel syndrome (a disorder that leads to abdominal pain and cramping and changes in bowel movements), stress incontinence (involuntary urination due to pressure on abdomen), and constipation. Review of the Admission MDS (Minimum Data Set-a required assessment) dated 12/19/12, identified the resident with a BIMS (Brief Interview for Mental Status) score of 15/15 (indicated little to no cognitive impairment). Review of the resident's Significant change MDS (Minimum Data Set-a required assessment) dated 3/18/13, identified the resident with a BIMS (Brief Interview for Mental Status) score of 12/15 (indicated moderately impaired cognition).	F 441		

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Review of the care plan revealed it does not address the staff's use of Styrofoam plates or plastic drinking ware of silverware, or mention of the resident's isolation.

Review of the physician's orders revealed on 4/29/13 the physician wrote an order that identified the resident had shingles (an acute painful infection/inflammation of a nerve in the area of skin around it that results in skin eruptions often forming a girdle around the middle of the body).. The physician did not order the staff to place the resident in isolation in his/her room.

On 5/6/13 at 10:07 a.m., observation revealed the staff served the resident the noon meal to the resident in his/her room. The meal came on a Styrofoam plate, with plastic silverware and plastic cups. The resident stated he/she had to eat in his/her room, because he/she had shingles which he/she identified were on his/her back. The resident said that he/she not like being served on paper plates. When asked why the staff did that, the resident said "I don't know, I guess it's so they don't have to wash them. I don't like it."

On 5/7/13 at 12:07 p.m., observation revealed the dietary staff served the resident food on Styrofoam plates and bowls. The resident received plastic silverware and cups, also.

On 5/8/13 at 9:00 a.m. observation revealed the resident sat in a wheelchair in his/her room, finishing eating. Staff had served the meal on Styrofoam plates, plastic cups and silverware.

On 5/7/13 at 12:03 p.m., Direct care staff E stated

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the resident was on isolation due to shingles. Staff E stated the resident was not allowed to come out of his/her room because of the isolation. Staff E stated the blisters had started a week ago, and the resident was tired of staying in his/her room--Staff E described the resident as a big participant of the activities and being on isolation had been a real challenge for him/her. Staff E stated the only time the resident was allowed to come out of his/her room was during showers and then someone had to make sure and sterilize the shower room afterward.

On 5/7/13 at 3:18 p.m., Direct care staff F stated the resident was on isolation due to shingles that are on the resident's lower back and side. Staff F described the isolation for the resident included the resident not allowed to come out of the room and the resident had dedicated equipment, including the lift.

On 5/8/13 at 11:10 a.m. Dietary staff G and H stated that whenever a resident went on isolation, the residents automatically received disposable paper products with their meal for dishware. Both staff G and H confirmed that resident #5 was currently on isolation and getting disposable dishware.

On 5/9/13 at 9:14 a.m. Dietary staff D identified resident #5 was on isolation because of shingles. Staff D identified Dietary personnel were not to go into the room and all residents on isolation are given disposable dishware. Staff D identified that as soon as the doctor lifted the isolation, the dietary staff would gladly welcome the resident back to the dining room. Staff D identified the resident really struggled with the isolation as the

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resident enjoyed spending time outside of his/her room, including the dining room.

On 5/9/13 at 12:51 p.m. Licensed nursing staff J stated that the isolation was just something that the facility did when a resident got shingles, it was not something the doctor ordered.

On 5/9/13 at 2:51 p.m. Administrative Nurse K stated he/she did not know why they placed the resident on strict isolation, it was something he/she thought he/she was supposed to do. Nurse K agreed the resident really wanted out of that room.

Review of the CDC (Centers for Disease Control) website revealed shingles cannot be passed from one person to another. However, the virus that causes shingles, the varicella zoster virus, can be spread from a person with active shingles to a person who has never had chickenpox. In such cases, the person exposed to the virus might develop chickenpox, but they would not develop shingles. The virus is spread through direct contact with fluid from the rash blisters, not through sneezing, coughing or casual contact.

Shingles is less contagious than chickenpox and the risk of a person with shingles spreading the virus is low if the rash is covered.

If you have shingles
Keep the rash covered.
Do not touch or scratch the rash.
Wash your hands often to prevent the spread of varicella zoster virus.
Until your rash has developed crusts, avoid contact with

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pregnant women who have never had chickenpox or the varicella vaccine;
premature or low birth weight infants; and
immunocompromised persons (such as persons receiving immunosuppressive medications or undergoing chemotherapy, organ transplant recipients, and people with HIV infection).

Patients in the healthcare setting:
Infection-control measures depend on whether the patient with herpes zoster is immunocompetent or immunocompromised and on whether the rash is localized or disseminated. In all cases, standard infection-control precautions should be followed.
If the patient is immunocompetent with localized herpes zoster, then standard precautions should be followed and lesions should be completely covered.
disseminated herpes zoster (defined as appearance of lesions outside the primary or adjacent dermatomes), then standard precautions plus airborne and contact precautions should be followed until lesions are dry and crusted.
If the patient is immunocompromised with localized herpes zoster, then standard precautions plus airborne and contact precautions should be followed until disseminated infection is ruled out. Then standard precautions should be followed until lesions are dry and crusted.
disseminated herpes zoster, then standard precautions plus airborne and contact precautions should be followed until lesions are dry and crusted.

Review of the facility's undated policy and

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procedure for Isolation/Use of paper goods policy revealed the following:
POLICY: Standard procedures for the use of paper or disposable goods as a barrier for infectious disease control.

1. When specific organisms are identified, the use of paper or foam, disposable dining products, is warranted to significantly decrease the spread or contraction of many infectious diseases. Those individuals identified as such, the dietary department will issue all of the foodstuffs coming from the kitchen on disposable paper. The only re-wash/sanitize part the meal will be the tray. The tray will have specific care instructions and is to be handled with gloves, washed 2 times in the high temperature dish machine and then returned to common use. All paper goods used for the individual will be discarded in the appropriate container within the resident's room. These bags will be disposed of in a safe and sanitary manner by a member of the nursing staff. The staff will be required to wear gloves at all times when dealing wit these specified trays.

2. To control and further outbreak or communication of said illness, the dietary staff will not deliver the tray directly to the resident, but leave it in a central location so that the nursing staff can distribute it as needed. This also facilitates cueing or individualized assistance of the meal by the nursing staff. The dietary department is to have no physical contact with said disposables after the resident has touched them.

3. Because of the dietary department role in the production and distribution of all meals and most

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F 441	Continued From page 192 of the snacks and drinks, it is imperative that hand washing procedures for all involved in the infectious control are aware, trained and execute proper hand washing and care in dealing with the products and residents. 4. These procedures are especially warranted when an individual has been placed under a "RED BAG" warning by their physician. The facility failed to obtain a physician's order for isolation and failed to follow standard practices for handling a resident with shingles in a manner sufficient to prevent the spread of the infection without unnecesarily restricting the resident's activities.	F 441		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the	F 520		

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requirements of this section.

Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.

This REQUIREMENT is not met as evidenced by:
The facility census totaled 50 residents. Based on interview and defiencies identified during the annual survey completed on 5-9-13 the facility failed to develop and implement an effective system to identify and ensure action plans were developed through the Quality Assessment and Assurance (QAA) program to address concerns for residents who received dialysis, positioning of resident's in wheelchairs, behavioral issues with depression, activities, infection control and isolation, monitoring of medications for effectiveness, falls, and individualizing care plans. This failure had the potential to affect all 50 residents.

Findings Included:

- Based on an interview on 5-9-13 at 4:59 p.m. Administrative nurse K reported the QAA committee only identified positioning problems in wheelchairs if a resident needed a new wheelchair. The facility failed to identify an action plan regarding proper positioning of residents who leaned over or did not fit properly in wheelchairs. Please see F-309 for additional information.

- Based on an interview on 5-9-13 at 4:59 p.m. Administrative nurse K reported the QAA

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committee had not identified any concern regarding dialysis in the past. The facility failed to identify an action plan regarding the monitoring of the fistula site and overall care of a resident on dialysis. Please see F-309 and F-155 for additional information.

- Based on an interview on 5-9-13 at 4:59 p.m. Administrative nurse K reported the facility had identified concerns regarding activities in March of 2012 and in July 2012 the facility made some activity staff changes. The facility recently made some other changes and hoped that the program would improve. The facility failed to develop an effective monitoring and review system for the residents who wandered, had behaviors, or were a high risk for falls regarding activities. Please see F-248 for additional information.

- Based on an interview on 5-9-13 at 4:59 p.m. Administrative nurse K reported the QAA committee had not identified infection control and isolation as a concern in the past. The facility failed to identify an action plan regarding the isolation procedures for a resident with shingles. Please see F-441 for additional information.

- Based on an interview on 5-9-13 at 4:59 p.m. Administrative nurse K reported the QAA committee identified concerns regarding review of diagnoses and gradual dosage reductions on psychotropic medications as appropriate. Staff K reported that each nurse had 5 residents they are specifically responsible for writing on and monitoring medications and status and communicate concerns with physicians. He/she also reported the relationship that is built between that nurse and physician should help in getting

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better responses from the physicians. The facility failed to develop an effective monitoring and review system for residents who received medications that required monitoring for effectiveness and gradual dosage reductions. Please see F-329 and F-428 for additional information.

- Based on an interview on 5-9-13 at 4:59 p.m. Administrative nurse K reported the QAA committee had discussed hydration regarding passing fresh ice water so the residents would not be woke up. It was also discussed a couple of residents who would benefit from having fluids encouraged and staff educated regarding offering more than just when care provided but every 15 minutes or so. The facility failed to develop an effective monitoring and review system for a resident who was to have fluids encouraged. Please see F-327 for additional information.

- Based on an interview on 5-9-13 at 4:59 p.m. Administrative nurse K reported the QAA committee had not addressed it as a concern but stated it was a concern and hopefully getting the bladder diaries back will make a difference. Please see F-315 for additional information.

- Based on an interview on 5-9-13 at 4:49 p.m. Administrative nurse K reported the QAA committee had not addressed concerns regarding nurse staff, especially related to the training and monitoring of contract staff when working in the facility. Please see F-353 for additional information.

The facility failed to have a QAA program that identified care concerns and effectively reviewed

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F 520	Continued From page 196 care concerns. This failure had the portential to affect all 50 residents.	F 520		